A MIND OF YOUR OWN

Neurofeedback Training

Cristina Berard, RPh, MEd

401-486-5642

berardcristina@gmail.com

Contact Information

Client Name: _____

Date of Birth: _____

Address: **Street:**_____

City:_____**State:**_____**Zip Code:**____

If Under 18, Parent(s):_____

Emergency Contact: _____ **Relationship:**_____ **Phone:**_____

Primary Care Practitioner: _____ **Phone:** _____

Please list the means of communication you prefer and approve:

Home Phone Number:_____ **Leave Message? Y or N**

Mobile Phone Number:_____ **Leave Message? Y or N**

Work Phone Number:_____ **Leave Message? Y or N**

Email Address:_____

Sliding Fee Scale Per Session (please select one that fits your budget): __$70.00 __$80.00 __$100.00

It is important to remember that the above means do not represent a secure method of communication. Therefore, both parties should understand that confidential information should not be shared by these means. We should avoid dealing with personal issues that can be dealt with in the training session.

In case of an immediate crisis, 911 is the appropriate call to make.

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Statement Regarding Confidentiality

Neurofeedback training sessions are confidential in nature; however, the following topics of information, by law, cannot be treated as confidential:

1. **Threats against the physical well-being or life of another person**
2. **Suicide threats**
3. **Abuse or neglect of children, persons with disabilities or elderly individuals**

Your signature indicates that you fully understand and agree to these limitations on confidentiality in accepting neurofeedback training sessions in my practice. In addition, to safeguard confidentiality, your signature indicates that you will not seek to subpoena material disclosed in the sessions for the purpose of personal litigation at the criminal, civil or ecclesial levels against a spouse or other person(s).

Client (or Parent):_____ Date:_____

Neurofeedback Trainer:_____Date:_____

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Informed Consent For Neurofeedback Training

I hereby authorize Cristina Berard, RPh, MEd, to provide me or my minor child with Neurofeedback Training. I understand this training is used for a variety of conditions which appear to be associated with irregular brain activity, including but not limited to ADHD, depression, anxiety, stroke and seizure disorders. Training is recommended on the basis of empirical observation and improvement in clients with similar conditions.

I understand that this EEG Biofeedback requires placement of surface electrodes (sensors) on my scalp for the purpose of recording my EEG and the use of this signal to provide video displays and audio signals.

I understand that some individuals have reported that training may affect the response of my body to medications for my condition and unrelated conditions. I understand that I should not stop or alter any of my medications without consulting my physician/psychiatrist. I should continue ongoing therapies until otherwise advised by the physician. Should new symptoms develop, it is my responsibility to inform my health care providers including Cristina Berard, RPh, MEd.

I understand that it is my own responsibility to monitor the subjective effects of training. Neurofeedback is based on input from the client or parent report from day to day sessions, as well as the initial evaluation, and depends on the full participation of the client (i.e. his/her feedback about the effects of training). The research literature indicates that there are some individuals who are apparently unaffected by the training. Accordingly, the client is urged to evaluate progress after about ten sessions to determine if further training is indicated. Discussion is invited at this point or any time during the training.

No representation is made that any individual client will improve from training. There is some indication that client improvement may fall off after the cessation of training. These individuals would benefit from periodic follow up or booster sessions. The training is non-invasive and appears to be a harmless procedure as far as is presently known. No injuries are known to be reported in the literature.

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Please initial the following statements:

__I am currently under the care of a physician or other health practitioner.

__I understand that no practitioner-patient relationship is established through my participation in neurofeedback training.

__During neurofeedback sessions a list of options may be suggested, but I agree that before undertaking any of these options, I will consult with my physician or other healthcare practitioner whose care I am currently under.

__I acknowledge by signing this form that I have not been hospitalized for psychiatric reasons within the last three (3) years.

__I understand that Cristina Berard, RPH, MEd, reserves the right to refuse neurofeedback training at any time.

__I understand that a neurofeedback session is not a medical diagnosis, treatment, or medical advice: therefore I understand that Neurofeedback Training sessions will not provide prescription, treatment or therapy.

__I also understand that Neurofeedback is not usually reimbursable by medical insurance.

__I understand that a 24 hour cancellation notice must be given, otherwise I will be charged.

__I understand that if I'm 15 minutes late I might have to reschedule my appointment.

By signing this form, I indicate my understanding of the principles set forth here and waive any claim of damages due to training including worsening of my condition for which the training was undertaken, claimed side effects or the failure to improve with training.

Client (Parent) Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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For Life Coaching Sessions Only Please Sign Here

Life coaching sessions are meant to help the client reach their goals. Once the goals are clear, the journey begins in identifying strengths and weaknesses and any obstacles that may be getting in the way. Life coaching is not psychotherapy. Referrals will be made if appropriate.

Please explain what you are looking to get from these sessions:

_____

_____

_____

Client's Signature_____**Date:**_____

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Written Acknowledgement of Receipt of Privacy Practices

A copy can be found at www.amindofyourown.com

I acknowledge receipt of the notice of privacy practices:

_____ _____

Client's Name Client's Authorized Rep.

_____ _____

Client's Signature Relationship to Client

_____

Date

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Consent to Treat a Minor Child

I hereby give Cristina Berard, RPh, MEd, consent to provide Neurofeedback Training to my minor child.

_____

Print Child's Name

_____

Date of Birth

Signature of Parent or Legal Guardian:_____

Relationship to Child: _____

Date: _____

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Intake Information

Name:_____ Date:_____

Do you have any allergies? _____

_____

Please list symptoms that you are experiencing and hope to improve with Neurofeedback Training:

_____

_____

What have you done so far to help with this condition?

_____

_____

What diseases or conditions have you been diagnosed with?

_____

_____

_____

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Please circle if you've had any of the following issues?

Head Injury Accidents Trauma Abuse Neonatal Complications

Please list any medications you are currently taking (include over the counter medication you occasionally take:

_____

_____

_____

_____

Please list any supplements you are currently taking:

_____

_____

Do you use recreational drugs?_____

Are you sensitive to medication? _____

Are you sensitive to fluorescent lighting?_____

Are you sensitive to smells?_____

Are you sensitive to sounds(noise)?_____