INFORMED CONSENT

I, _____, authorize Amy Warren, LMHC to provide me with Neurofeedback Training. lunderstand this training is used for a variety of conditions which appear to be associated with patterns of brain activity. These include, but are not limited to, mood regulation, ADHD, focus, depression, anxiety, stress, sleep, obsessive thinking, seizures and migraines. Training is recommended on the basis of empirical observation of improvement with clients with similar conditions. Published research shows improvement with ADD/ADHD, seizures, substance abuse, depression, sleep and autism.

I understand neurofeedback (EEG biofeedback) requires placement of sensors on my scalp for the purpose of recording my EEG. This signal is used to provide video display and audio signals.

I understand that training may affect my body's response to medications. Although some people have been able to reduce or eliminate after neurofeedback, I understand I should not stop or alter taking my medications without consulting my physician/psychiatrist. Should new symptoms develop, it is my responsibility to inform my health care providers including my neurofeedback practitioner.

I understand that training is based on client input, and it is my responsibility to monitor and report any perceived effects of neurofeedback training. Feedback includes any changes noticed by you or others after training begins.

Though a large number of clinicians have reported their progress with clients, no representation is made that any individual client will improve with training. Training effects typically do not begin to show until 10-20 sessions. The training is noninvasive and appears to be a harmless procedure as far as is known at present. There are no known adverse effects reported in the literature.

I understand that if I don't notify the office of Amy Warren, LMHC of any cancellations by phone at least 24 hours in advance, I will be charged for the missed session. There are no refunds on pre-paid sessions. Sessions purchased as part of a package expire one year from the date of purchase and are non-refundable.

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

Name:_____

Signature:_____ Date:_____

Release of Information:

I authorize Amy Warren, LMHC to communicate relevant case information and symptoms with technician operating under the direction of Amy Warren, LMHC. I also agree Amy Warren, LMHC may consult with my primary care or referring practitioner, _____, with regard to the EEG training and obtained results.

Signed by _____Date:_____

Print Name:_____

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