STATEMENT OF UNDERSTANDING AND CONSENT TO TREATMENT

1. **Fees**

(1) I understand that I will be charged a regular fee of $110.00 per 50 minute session for clinical counselling, neurofeedback and related services, plus GST.

(2) As evidenced by my signature below, I agree to pay this fee on the terms and conditions set out in this agreement.

2. **Missed appointments**

(1) I understand that I am responsible for notifying the clinic at least **24 hours** in advance of a scheduled appointment if I will miss that appointment.
(2) As evidenced by my signature below, I agree that if I do not give at least **24 hours** advance notice to the counsellor, I will pay the counsellor a cancellation fee equal to half of the amount I would normally have been charged for attending that appointment ($55.00 plus GST).

3. **Late Arrivals**

I understand that if I am late arriving at the Clinic and therefore attend only a part of a scheduled appointment that I am nonetheless responsible to pay the counsellor the full fee that would be charged for the total time of that appointment.

4. **Confidentiality and Client Rights**

Client progress notes will be electronically maintained and securely encrypted throughout the counselling process in accordance with The Personal Information Protection Act (PIPA). Exceptions to confidentiality include but are not limited to:

- Imminent self harm, danger to others, or medical emergency
- Subpoena or court order
- Child Welfare Concerns

5. **Health plan reimbursements**

(1) I understand and agree that I am solely responsible for confirming the scope of coverage of, and for seeking reimbursement for the cost of clinical counselling, neurofeedback, and related services from, any insurance, pension, benefit or similar plan of which I am a beneficiary or have an insured interest.

(2) I further understand that should my health plan not reimburse me for the full cost of the clinical counselling services that I have paid to the counsellor, I remain responsible for those additional costs and the counsellor will not refund me the difference.

6. **Unpaid fees - BCAA Clinical Guidelines**

(1) I agree to pay the counsellor the fee for each session immediately prior to or following that session

(2) I further understand that if the counsellor does not receive such prompt payment, the counsellor is entitled to initiate legal proceedings against me for the amount of the unpaid fee

(3) I understand that if I am not satisfied that the counsellor has addressed a concern I may have about our financial arrangements, I may contact the Registrar at the BC Association of Clinical Counsellors at 1-800-909-6303

8. **Consent to Treatment for Clients Receiving Neurofeedback Services**

Practitioner is a Registered Clinical Counsellor and Doctor of Psychology Candidate. She is certified in Neurofeedback and is a current member of the International Society for Neurofeedback and Research (ISNR). This Practitioner adheres to all guidelines in accordance with the Code of Ethical Principles and Professional Conduct of ISNR.

The first session of Neurofeedback (NFT) will consist of an objective assessment of brain activity and psychological status. Neurofeedback "training" sessions will follow. During assessment and training, sensors are placed on the scalp and then connected to sensitive electronics and computer software that detect, amplify, and record specific brain activity. Resulting information is fed back to the trainee (client) virtually instantaneously with the conceptual understanding that changes in the feedback signal indicate whether or not the trainee's brain activity is within the designated range. Based on this feedback, changes in brain patterns occur and are associated with positive changes in physical, emotional, and cognitive states. Often the trainee is not consciously aware of the mechanisms by which such changes are accomplished although people routinely acquire a "felt sense" of these positive changes and often are able to access these states outside the feedback session.

NFT does not involve surgery or medication and is not painful. Neurofeedback training generally produces few, if any, negative side effects and there are few published reports of side effects. Clients usually find neurofeedback to be an interesting and engaging experience that feels good. Some individuals report feeling somewhat fatigued following a treatment session and in this case it may be helpful to schedule your sessions for later in the day, or at a time when you can rest after. A smaller percentage of individuals report experiencing discom-forting physical and emotional feelings (lightheadedess, sad-ness) that last for a brief period of time. The majority of individuals experience positive side effects such as decreased level of stress and anxiety, an increased level of confidence and relaxation and IQ enhancement. Please let your Practitioner know if you experience any unwanted side effects.

Neurofeedback is utilized for assessment and treatment of conditions assessed by qualified healthcare providers, training for optimal performance and both clinical and applied scientific research. Ongoing research and clinical experience have demonstrated the effectiveness of neurofeedback interventions for a wide variety of conditions. <u>However, please note that this PRACTITIONER makes no claim or guarantee that neurofeedback training will be effective for your specific concerns</u>. In order to ensure that you are an appropriate candidate for neurofeedback services, it is your responsibility to disclose any pre-existing medical or mental health conditions, and any medications that you are currently taking. Please note that for some conditions including psychosis, bipolar disorder or schizophrenia, your Practitioner may recommend alternative treatment options.

In order to ensure the most streamlined and comprehensive plan of care, this Practitioner may request permission to notify your family physician that you are receiving Neurofeedback services. This is of particular importance for clients that are currently taking certain medications which may need to be monitored and adjusted as improvements occur with Neurofeedback training.

9. **Signature**

I have read and understand this agreement, and as evidence by my signature, I agree to pay the counsellor according to the above terms and conditions.

_____
Printed Name

_____
Signature

_____
Date signed

MEDICAL HISTORY FORM

Name: Phone: E-Mail:

Address:

Age: Date of Birth:

Family Doctor: Date of last medical exam:

Referral Source:

Prescription Drugs (Current):

Name of drug	Daily dose distribution	How long have you been taking it?	Reason taking Medication

Non - Prescription Drugs (Current):

Name of drug	Daily dose distribution	How long have you been taking it?	Reason taking Medication

1. DIAGNOSIS OR RECENT MAJOR ILLNESS

Year	Nature of Illness / Diagnosis	Treatment	Result

2. RECENT SURGERY

Year	Type of Surgery	Reason for Surgery	Result

3. RECENT HOSPITALIZATIONS

Year	Illness	Treatment	Result

4. OTHER SERVICE PROVIDERS I AM CURRENTLY SEEING OR HAVE SEEN RECENTLY

Dates	Name of Provider	Type of Treatment	Result

SYMPTOM CHECKLIST & FAMILY HISTORY

Please indicate if YOU and/or **family member(s) currently experience** or have a **history** of any of the following symptoms.

										Mother's		Father's	
	ME	Mother	Father	Sisters	Brothers	Aunts	Uncles	Spouse	Children	M	F	M	F
Anxiety													
Sleep Problems													
Headaches													
Head Injury / Concussion													
Attention Problems													
Hyperactivity													
Vocal or Motor Tics													
Depression													
Bipolar Disorder													
Schizophrenia													
Suicide (failed attempts)													
Suicide (completed)													
Early/Late Dementia													
Alcohol abuse													
Drug abuse													
Other Addictive behaviours (i.e. internet, gambling)													
Child Behavior Problems													
Imprisonment/detention													
Learning Disability													
Eating Disorder													
Physical Abuse													
Sexual Abuse													
Abusive Behaviours													
Any psychiatric hospitalization													
Feeling Panicky													
Repetitive Thoughts													
Repetitive Behaviour													
Allergies													
Seizures/Epilepsy													
Chronic Pain													
Food Sensitivity													
Memory Problems													
Tremors													

NO INFORMATION ON BIOLOGICAL: ☐ Mother ☐ Father ☐ Either Parent

For clients seeking neurofeedback services: please note that it is your responsibility to disclose any pre-existing medical or mental health conditions, and any medications that you are currently taking in order to provide optimal treatment and to ensure that you are an appropriate candidate for neurofeedback. For some conditions including psychosis, bipolar disorder or schizophrenia, your Practitioner may recommend alternative treatment options or resources.

MY REASONS FOR SEEKING COUNSELLING / NEUROFEEDBACK INCLUDE:

MY ANTICIPATED GOALS INCLUDE:

Authorization for Release of Information

I, _____,
(printed name)

authorize _____ to release Information pertaining to
(name of service provider)

treatment plan of care and coordination of treatment services to:

_____ _____

(name of physician) (name of treatment provider)

_____ _____

(name of treatment provider) (name of treatment provider)

Signature _____

Date _____