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 your child is an appropriate candidate for neurofeedback services, it is your responsibility to disclose any pre-existing medical or mental health conditions, and any medications that your child is 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 child's family physician that your child is 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 of Parent

_____
Printed Name of Child/Adolescent

_____
Signature of Parent

_____
Date signed

CHILD & ADOLESCENT
DEVELOPMENTAL MEDICAL HISTORY QUESTIONNAIRE

Date:_____

Child/Youth Name: _____

Birth date: _____

Age:_____

Name of the Parents/Guardians: _____

Home Address: _____

Home Phone: ( ) ____- _____Cell Phone: ( ) ____- _____ e-mail:_____

Person completing this form: _____

Relationship to child: _____

What are the problems that caused you to seek help for your child?

_____

_____

Who referred you to me? _____

<u>Family History</u>:

1. Child is living with:
   □ Both parents □ Mother □ Father □ Grandparent(s)
   □ Mother & Stepfather □ Father & Stepmother □ Legal Guardian
   □ Other: _____

2. Is the child adopted:
   □ Yes □ No Child's age at adoption: _____

3. Status of parents' marriage:
   □ Married □ Separated □ Divorced □ Widowed □ Single
   How long married? _____ How long divorced? _____ Child's age at divorce: ____

4. Father's Name: _____ Age:_____ Education: _____
   Employed: _____ Work phone: _____
   Type of work: _____

5. Mother's Name: _____ Age:_____ Education: _____
   Employed: _____ Work phone: _____
   Type of work: _____

6. List the people who live at home:

Name:	Age:	Relationship to child:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Please provide any other information about the child's extended family that might help to understand the child's needs (e.g., medical, developmental, behavioral, educational, emotional, or psychological):

_____
_____
_____
_____

Birth and Developmental History:

Pregnancy:

Length of pregnancy: _____ Illness or complications while pregnant? □ Yes □ No

If yes, please explain: _____

Medications used **during** the pregnancy: _____

Substances used **during** the pregnancy:

□ Cigarettes How many? ___ How often? (day/week): _____

□ Alcohol How many drinks? ____ How often?(day/week/month):_____

□ Drugs Please describe type and frequency of use: _____

Labour and Delivery:

Was your child's birth without complications? □ Yes □ No _____

Were there any concerns at birth related to lack of oxygen (e.g., born "blue"?): □ Yes □ No

Perinatal History:

Birth weight: _____ Length: _____

Did mother or baby stay in Special or Intensive Care? □ Yes □ No

Please describe any problems: _____

Please list any complications or concerns regarding infancy or early childhood development:
_____
_____
_____
_____

Please list any complications or concerns regarding developmental milestones (walking, feeding self, speech, fine motor development):
_____
_____
_____
_____

Overall rate of development: □ Slow □ Normal □ Fast

Medical History:
Pediatrician's Name: _____

Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? □ Yes □ No

If yes, please describe condition/injury, treatment, any surgery, how long, and where.
_____
_____
_____

Has your child been diagnosed with a chronic health condition? □ Yes □ No
If yes, please describe: _____

Does your child take any medication on a regular basis? □ Yes □ No
If yes, please list the name and dosage: _____

Behavioral and Mental Health History:
1. Please describe any behaviors that are particularly concerning to you or others:
_____
_____
_____
_____
_____

2. Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child' age at the time, and comments.
_____
_____
_____

3. Has the child or family received any professional mental health treatment, such as individual or family counselling, group counselling, etc.? □ Yes □ No

If yes, please give the name of previous therapist:

_____

4. Interactions with peers: □ No friends □ Few Friends □ Loses friends
□ Trouble making new friends □ Mean, aggressive □ Too shy or too timid
□ Bossy, controlling □ Risky behaviors

Has your child experienced any of the following:
□ Being teased or bullied □ Teasing/bullying others □ Peer rejection □ Popularity with peers

5. Has your child or any of your family members struggled with any of the following problems? Place checkmark in all that apply:

Condition	Child Current	Child Past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety, Excessive worries						
Panic Attacks						
Obsessions/Compulsions						
Tics: vocal / motor						
Headaches						
Head Injury or Concussion						
Suicidal Thoughts						
Attempted Suicide						
Learning Disability						
ADHD						
Problems with anger						
Problems with Assertiveness						
Opposition or Defiance						
Problems with the Law						
Schizophrenia/Psychosis						
Nervous Breakdown						
Heavy Alcohol Use						
Drug Use						
Eating Disorder						
Abuse/Neglect						

Other: _____

_____

_____

Education History:

Current grade: _____ Name of School: _____

Counsellor/Teacher's Name: _____

Type of school: □ Public □ Private

Have there been any comments/concerns from the school regarding your child's behavior?

_____
_____
_____

What does your child do best in at school

_____
_____
_____
_____

Please check any concerns or difficulties your child has in school:

□ Does not do homework	□ Excessive time to complete assignments	□ Distracted
□ Poor handwriting	□ forget assignments	□ Test Anxiety
□ Does not remain seated	□ Starts but does not finish homework	□ Noncompliant
□ Incomplete classroom work	□ Excessive talking	□ Disorganized
□ Poor attention in class	□ Careless errors	

Has your child ever been retained a grade? □ Yes □ No. If yes, which grade? _____

Has the child been placed in special education programs currently or in the past? □ Yes □ No

Does your child have:

1. Learning disability (LD): □ Yes □ No. Subjects: _____
2. Language disorder: □ Yes □ No. Type: _____
3. Tutoring: □ Yes □ No. Where: □ School □ Other: _____
4. An Individualized Education Plan (I.E.P.) □ Yes □ No

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 _____