Neurofeedback
THERAPEUTIC SOLUTIONS

INFORMED CONSENT FOR NEUROFEEDBACK THERAPY

I hereby authorize Neurofeedback Therapeutic Solutions to provide me/my child with neurofeedback Therapy also know as biofeedback for the brain. I understand that I have the right to stop training as any time for any reason. I agree to talk with my provider if I am uncomfortable with any aspect of this training. I realize that the neurofeedback Professional is not a medical doctor, but is fully trained in the therapeutic use of brain wave training.

Neurofeedback training is a non-invasive approach that can help the brain learn to manage symptoms that are associated with mental health disorders and increase positive performance levels at home, in school, at work, athletic activities, and/or other artist outlets. The potential benefits and risk have been explained to me by Kimberly Milam, LPC, NCC.

Some people have reported that neurofeedback affects the body response to medications. I agree to talk with my doctor about my participation in neurofeedback and understand that I must consult with my psychiatrist or other doctors before changing how I use my medications. I understand that it is my responsibility to inform my doctor as well as the neurofeedback professional if other symptoms develop. I understand that brain training may make some people more sensitive to drugs or alcohol.

Training is more likely to be successful if it is done regularly (i.e. twice per week) and if it is supported by other brain health, including sufficient sleep, active exercise, and nutritious foods. Environmental stressors may impede progress.

By signing this form, I indicate my understanding of these principals and responsibilities and wave any claim of damages due to training including worsening of the condition for which the training was undertaken, claimed side effects, or failure to improve with training.

Name of client	Signature	Date

Name of parent/guardian	Signature	Date

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