The Balanced Brain

NEW CLIENT INTAKE FORM

Name: ____ **Date** ____/_____/______

Street: ____________________________________ City: __________________________

State: ___ **Zip:** __________ **Sex:** ____ **DOB** ____/____/______

Home Phone: __________________________ **Cell:** ____________________________

Work: _________________________________ **Other:** ____________________________

email: _______________________________ **Occupation:** __________________________

If client is a minor, Parents/Caregivers names _____________________________________

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Emergency notification: _____________________________ **Phone:** ___________________

How did you hear about me? ____

(Referral, Internet search, Print ad, other)

Please send me the Balanced Brain Newsletter (you can opt out at any time)

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The Balanced Brain does not serve as a participating provider for any insurance companies.
All fees are to be paid at the time of service unless prior arrangements have been made.
You may be able to obtain reimbursement for your payments from your insurance carrier,
although I do not guarantee such reimbursement.
I will provide you with a statement to submit to your carrier.

The Procedure

One or more sensors are placed on the scalp and/or ears (with water-soluble paste) to pick up your brain waves, the electrical activity created in the brain. This electrical activity then passes through an amplifier (an FDA approved device) to a computer where the software is designed to give positive feedback via sights and sounds when the training conditions are met. At no time is any electrical current introduced to the brain.

Neurofeedback Training Consents

Please initial:

_______ I give my consent to be trained with Neurofeedback.

_______ I acknowledge that I have been given an opportunity to ask questions regarding the training and that these questions have been answered to my satisfaction.

_______ I understand that I may discontinue training at any time, and that I may refuse to consent without penalty.

_______ I understand that neurofeedback is not a medical procedure and that it is not intended to treat or cure any medical condition. Pursuant to California law, neurofeedback providers are not required to be a licensed healthcare professional and John Mekrut is not.

_______ I understand that neurofeedback training is not intended to diagnose neurological disorders, nor will a neurologist be reviewing these records.

_______ I understand that my records are private to the fullest extent of the law; that is, except in cases of potential harm to myself or others, or in civil or criminal proceedings and with a court order.

_______ I give my full permission for my case history to be anonymously discussed at Hope Psychiatry team meetings in furtherance of gathering other professional opinions on your case and to discuss possible adjunct therapies.

_______ I give my full permission to John Mekrut to use any data collected during the preparation and participation in the Neurofeedback sessions, and I give up all implied and actual ownership of any data collected. I understand that when data is used, my confidentiality will be protected, and that my identity will not be revealed unless required by law.

_______ Cancellation policy: I understand that if I cancel the same day, or do not show for an appointment, I may be charged a cancellation fee equal to my session fee. I understand that short-notice cancellations are acceptable for illness or unsafe driving conditions.

Name of client:________________________________

________________________________ ______________

Signature of client or representative Date