Doric George MA

11600 Washington Place, Suite 208
Culver City, CA 90066
310.717.1771

CONFIDENTIAL

Consent to Train with Neuro Feedback

We, _____ &_____, The parents of: _____ (Child) understand that Doric George, MA, LPCC, LMFT (the therapist) is a Licensed Professional Clinical Counselor (LPC208) and a Licensed Marriage and Family Therapist (MFC38343) in the State of California and is certified in the Othmer Method Neuro feedback and also uses the New Mind Technologies Brain Mapping System.

I understand that neuro feedback requires the placement of surface sensors on the scalp for the purpose of recording EEG and uses this signal to provide feedback in the form of video display or games. While there are few risks associated with this procedure, there is a remote possibility of skin irritation from the paste that is used to attach the sensors. The techniques used to attach the sensors have been used at numerous research institutions for many years and no deleterious side effects have been reported. No alternatives to this procedure exist at the present time. It is a universally used procedure for the recording of the EEG, and a necessary tool for the evaluation of brain function in various contexts. I understand that I can remove the electrodes at any time, if I so desire. There is no risk of electric shock from this procedure.

I understand some individuals have reported that neuro feedback training seemed to produce a temporary worsening in some symptoms including feeling more anxious, more distractible, headaches, sleep disturbance, etc. These reactions can usually be resolved by changing training protocols. I also understand that training may affect my body's response to medications. I understand that I should not stop or alter any of my medications without consulting my physician. Should new symptoms develop, it is my responsibility to inform my health care providers including EEG biofeedback providers.

I understand that if any adverse reaction does occur beyond the scope of this practice, I will be informed of appropriate medical and psychological services and provided with contact information, if so requested.

I have also disclosed all pertinent medical and psychological information that could affect the course of this treatment. I further understand that these sessions are not a substitute for medical treatment as indicated.

I understand that I am responsible for weekly appointment times and will be charged the full session fee for all canceled or missed appointments, unless the cancellation by end of business Friday(5pm PST) the week before the appointment day. There will also be a $20.00 charge for returned checks.

I understand that this therapist does not maintain a 24-hour crisis hotline. However, every effort will be made to return calls as soon as possible, usually on the same day. If I have not received a prompt response, I will leave a second message. In the case of an emergency or urgent situation I will call an appropriate crisis hotline or 911.

I understand that complete professional confidentiality will always be maintained including the content and the fact of our therapy sessions except under certain circumstances as mandated or allowed by law, such as the presence of a reasonable suspicion of child abuse or a serious danger to client or others. I have received, read and understand the HIPPA compliance disclosure statement.

Therefore, we hereby authorize and give our consent to Doric George MA to provide neuro feedback training to our child.

Signature of Parent_____ Date_____

Signature of Parent_____ Date_____

Signature of Child_____ Date_____