Adriana Costin
Certified Biofeedback Specialist

2710 South Rochester Road, Suite 4,
Rochester Hills, MI, 48307

Phone: 248-812-8786
E-mail: ab2synergy@gmail.com
Web address: https://ab-synergy.com/

INFORMED CONSENT FOR BIOFEEDBACK TRAINING

What is Biofeedback Training?

Biofeedback is a technique that measures key functions of the body and based on the result the device is able to address the imbalances by delivering healthy frequencies through the harnesses attached to your body, helping the body to return to its ideal state.

The QuexEd biofeedback system that we use is **cleared by the FDA as a Class 2 medical device.**

What to expect from a Biofeedback session?

The scope of my practice through the use of this biofeedback system includes **stress reduction, relaxation training, pain management, muscle re-education and brain wave relaxation training**. Although this training is expected to produce beneficial results, such results cannot be guaranteed. Biofeedback training is a complement, not a substitute for medical or psychological treatment and any ongoing treatment should not be discontinued without advice of your treating physician.

Do you wear a pacemaker? YES ☐ NO ☐

Do you wear other implantable electrical devices? YES ☐ NO ☐

If your answer to any of the two questions above is 'YES', you should not proceed with biofeedback therapy because the electrical frequencies generated by the device could interfere with the operation of the pacemaker or other implantable electrical device.

Biofeedback therapy is non-invasive. It is important to notify the practitioner if your medical history changes such as becoming pregnant or if you have been diagnosed with an unexpected medical condition.

Please check or circle one of the multiple options in a line if you have or have had any of the following:

ACNE / ECZEMA / PSORIASIS / DRY SKIN	DIFFICULTY SWALLOWING	INFERTILITY / MISCARRIAGE
ALLERGIES	ENDOMETRIOSIS	KIDNEY PROBLEMS
ARTHRITIS	EMPHYSEMA	LIVER PROBLEMS
ATHEROSCLEROSIS	EPILEPSY	LOW IMMUNE SYSTEM =>FREQUENT INFECTIONS
ASTMA	ELEVATED CHOLESTEROL	MEMORY IMPAIRMENT / INABILITY TO CONCENTRATE
BIRTH DEFECTS	EYELID SWELLING (PUFFY EYES)	MOOD CHANGES / IRRITABILITY
BRITTLE NAILS	ENDOCRINE PROBLEMS	MIGRAINES / HEADACHES
BRONCHITIS	FLUID RETENTION	MONONUCLEOSIS / OTHER CHRONIC INFECTIONS
CANCER	GLAUCOMA / CATARACT	MUSCLE LOSS / MUSCLE WEAKNESS / MUSCLE CRAMPS
CHRONIC FATIGUE / FATIGUE / APATHY	GOUT	(PRE)MENSTRUAL PROBLEMS PAIN / IRREGULAR / FLOW CONCERN
CONSTIPATION	HAIRLOSS	OSTEOPOROSIS
COLD INTOLERANCE COLD HANDS AND FEET	HOARSENESS	THROAT PAIN
CYSTIC BREASTS	HERNIA	STROKE
CYSTIC OVARIES	HERNIATED DISK	UNDERWEIGHT / OVERWHEIGHT
DEPRESSION / ANXIETY / NERVOUSSNESS	HYPOTENSION / HYPERTENSION	OTHER:
DIABETES		

Family History: Please indicate if any family members have had any of the following medical problems and if so who:

DIABETES	HEART DISEASE	ALCOHOL PROBLEMS
HYPERTENSION	HEPATITIS / LIVER DISEASE	MENTAL / EMOTIONAL PROBLEMS
STROKE	CANCER	OTHER:

Describe and rate 1-10 any health concerns and your objectives in seeking wellness services here:

CONFIDENTIALITY

Client information will be kept in confidence and will not be disclosed to anyone outside of this office without your written consent.

CONSENT

I understand that the attending practitioner, Adriana Costin, is not a licensed doctor and does not portray herself as one, but is providing biofeedback training services. I understand that the service provided identifies energetic imbalances and the procedure utilized is stress reduction. I fully understand that the attending practitioner, Adriana Costin, does not offer allopathic drugs, surgery, chemical stimulants or any other conventional treatments. In addition, Adriana Costin does not diagnose, treat or otherwise prescribe for my disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited this service in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the practitioner to do biofeedback measurements and stress reduction protocols. By signing below I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask any questions with regard to the described procedures and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and any subsequent visit solely on my own behalf.

Client's Signature Client's Name Date

Phone # E-mail address

FOR PARENTS/GUARDIANS OF MINOR CLIENT

I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo biofeedback training.

Parent/Guardian's Signature Minor's Name Date