Capital Biofeedback, Inc.
Patient Consent Form

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, found in this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

In consideration of myself/child being permitted to participate in Biofeedback Services of Capital Biofeedback, Inc., I _____, for myself, my heirs, and my personal representatives, do hereby release and forever discharge Capital Biofeedback, Inc., all of its officers, agents, and employees from any and all claims for damages beyond the control of and without the fault or negligence of Capital Biofeedback, Inc., its officers, agents, or employees which are suffered by me as a result of myself/ child participating in biofeedback. I specifically assume all risks, which may arise from my/their participation. These risks are known and appreciated by me having read this release and knowing these facts, and in consideration of myself/child being allowed to participate.

BIOFEEDBACK/NEUROFEEDBACK SERVICES

According to the National Institute of Health "biofeedback is a treatment method that uses monitoring instruments to feed back to patients' physiological information of which they are normally unaware. By watching the monitoring device and with the help of the therapist, patients can learn by trial and error to adjust their thinking and mental processes in order to control bodily processes. Biofeedback can be used to treat a wide variety of conditions and symptoms ranging from stress, alcohol and other addictions, sleep disorders, epilepsy, respiratory problems, and muscle dysfunction caused by injury, migraine headache, hypertension, and a variety of vascular disorders" (p. 2). Since biofeedback uses signals sent from the body for interpretation and does not send any signals from the BF equipment to the patient, risk of any adverse effects are less than minimal.

Neurofeedback is a form of biofeedback which uses an electroencephalograph (EEG) to measure, process and feed back electrical activity of the brain. Working in the same manner as general biofeedback, one is able to regulate brain wave activity to improve attention and concentration, and alleviate symptoms of depression and anxiety. Research indicates that use of Neurofeedback has long term, permanent effects, increasing the person's ability to remain focused, and to spend extended periods of time concentrating in a problem-solving manner, and may even decrease impulsive actions (Journal of Neurotherapy, 2000). A combination of both biofeedback and neurofeedback is sometimes beneficial to reach optimal functioning.

Initial intake interview and evaluation is seventy-five (75) minutes in length and the fee is $149.00. After that, all other sessions are sixty (60) minutes in length and the fee is $130. Individuals receiving services are responsible for fees at the time of service in the form of cash or check. For best results, it is recommended to be consistent with the frequency of sessions. The number of training hours may vary based on the individual and progress.

CONFIDENTIALITY

All records will be kept confidential unless disclosure is required to protect you or others from harm, if child\adult abuse is suspected or when the courts order such disclosure. When disclosure is required only information that is essential will be revealed and you will be informed of such disclosures. The law protects the privacy of all communications between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

- If we believe that a patient presents an imminent danger to his/her health or safety, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services provided to you, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization, or a court order.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a complaint is filed against us, we may disclose relevant information regarding that patient in order to defend ourselves.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we have cause to suspect that a child under 18 is abused or neglected, or if we have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that we file a report with the County Director of Social Services. Once such a report is filed, we may be required to provide additional information.

- If we believe that a patient presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, calling the police and/or initiating commitment.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

Information collected may be used in research databases, without disclosing your personal identifying information.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality may be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Should you have questions about any of our policies or procedures, we encourage you to ask us. We are always interested in any suggestions you may have on how we may improve our services to you or your family.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, UNDERSTAND THAT THERE IS NO GUARANTEE ON YOUR PERSONAL RESULTS AND THAT YOU ARE ENTERING NEUROFEEDBACK TRAINING ON YOUR CHOICE, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Patient's Name: _____ Date: _____
(please print)

Signature: _____

Parental consent for patients under the age of 18:

I have carefully read and understood all of the contents in this form and I have explained these rules to my child and my child has agreed to follow all the rules listed above.

_____ Date: _____
Parent/Guardian Signature

PATIENT DATA:

Name:_____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

How do you prefer to be contacted: Work Home Cell

Fee Schedule

Ms. Tami Maes is currently an in-network provider for Blue Cross Blue Shield of North Carolina. She is considered an out-of-network provider for all other insurance panels. Individuals with BCBS, who have not met their deductible, will be expected to pay the full fee for services. These fees will be filed toward your deductible. Once you have met your deductible, you will be responsible for you co-pay at the time of service. Individuals who do not use BCBS will be expected to pay in full for services provided. A claim form will be generated for you if you so choose to file with your insurance company. At this time, the insurance company will reimburse you directly according to your policy. Reimbursement from your insurance company typically depends upon your insurance plan.

Your scheduled appointment time is designated for you and your training procedure. A 24 hour cancellation notice is requested. There is a fee for missed appointments and late cancellations. Any charge incurred is your financial responsibility. Please refer to the fee schedule listed below.

Procedure	Fee
Initial Intake & Assessments (75 minutes)	$149.00
Biofeedback/Neurofeedback Session (50 minutes)	$130.00
Missed Appointment	$60.00
Late Cancellation	$60.00
Phone Consultation (over the pd of 10 minutes)	$10.00/15 min
Cancelled check	$35.00

By signing this document I, _____ agree to the fee schedule above and will abide by these regulations.

Signature:_____ Date: _____