CONSENT FORM

Consent Form

This is a sample of a Consent Form. It is important that you have your counsel look over whatever form you create at your clinic. We highly recommend to include warnings on driving home after the first session, and that you are not their physician/they must consult a physician before changing any medication.

BENEFITS

I am aware and accept that while no guarantees about the results have been made, the Clarity Direct Neurofeedback (CDN) system has been seen to help the nervous system function in a more balanced, flexible and resilient manner in a wide range of conditions, including but not limited to anxiety, depression, post-traumatic stress disorder, ADD, substance abuse, autism and traumatic brain injury. Direct Neurofeedback has also been found to result in improvement in athletics and other areas of performance. I understand that if I don't complete a full course of treatment that a successful outcome is less likely. I understand that CDN results can be long-lasting but may not be permanent, and that occasional (yearly or bi-yearly) follow-ups may be needed. I understand that Direct Neurofeedback is not a specific medical treatment and is no substitute for effective standard medical treatment. If medical treatment is necessary, I agree to seek it if encouraged to do so by my clinician.

Safety

While the long-term effects of electromagnetic feedback as we use it is unknown, for reference, a double AA battery held against the forehead is at least 1,000 times stronger than the Direct Neurofeedback signal. Earlier versions of technologies similar to Direct Neurofeedback have been in existence since the early 1990's, yet we are not aware of any reports of someone being worse from having completed a course of treatment using Direct Neurofeedback.

Side Effects

1. Temporary side effects, especially early on, are not uncommon. In early sessions it is common for the brain to be overly "reactive" or get over-stimulated. The four most common "side effects" are

    a. Tired
    b. Wired (easily excitable)
    c. “Spacey”, or lightheaded
    d. Headache
2. These side effects are usually mild and typically last from minutes to hours, sometimes a day, and occasionally for up to a few days. These side effects are temporary.
3. There may also be a temporary change in sleep with more vivid dreams.
4. It is possible to have a temporary flare-up of presenting symptoms.
5. It is possible that anything you have experienced in the past, including anxiety, tics and even physical discomfort may temporarily return. These experiences are temporary, typically lasting from a few minutes to a few hours and rarely up to a few days.
6. I understand that if I do experience side effects, that in subsequent sessions modifications will be made so that side effects will be absent or reduced. Like giving medication, the dosage often needs to be adjusted, sometimes several times, based on response.
7. Direct Neurofeedback appears to act as an anticonvulsant and has led to medically supervised decreases in anticonvulsants. However, I understand that there have been reported seizures in those who have had prior seizures.
8. While Direct Neurofeedback can be helpful for migraines, it also possible to provoke a migraine.
9. I understand that effective treatment and relief from side effects depends on my giving my clinician accurate, timely information about those side effects.
10. I understand that I am a voluntary participant and may withdraw my consent and discontinue sessions of Direct Neurofeedback at any time.

Initial improvements are temporary, but with additional treatment these improvements typically last longer and longer until they are more “enduring”. We do not guarantee full or permanent resolution of symptoms. Some clients need “tune-ups”, or additional sessions. Because improvements are initially temporary, I understand that if I do not complete a full course of sessions that initial improvements are less likely to continue.

I also understand that most people typically require about 20-25 sessions but that this number can vary. In some conditions, including autism, severe stroke or traumatic brain injury, certain learning disabilities, etc., patients may require treatment for a significant period of time.

I have been advised that I should avoid making changes in my medications without the express written approval of my medical doctor. Further, I understand that I have been advised of the importance of advising my Neurofeedback clinician or technician of any and all change[s] in medication and/or dosage.

I acknowledge that I have read and understand this consent form and that the clinician or technician has fully answered all my questions to my satisfaction. I authorize _____ and associates and assistants, to perform Direct Neurofeedback sessions.

PERMISSION FOR SESSIONS:

I acknowledge and agree that I have been given an opportunity to ask questions regarding Direct Neurofeedback and that these questions have been answered to my complete satisfaction, and I hereby consent to evaluation and application of Direct Neurofeedback as discussed hereinabove.

Initial here:_____

_____	_____
Signature of Client/Guardian	Signature of Clinician/Technician
_____	_____