

# DOTSON CONSULTING AND COUNSELING, INC

---

## Neurofeedback Consent for Treatment

**Areas of Applicability:** Neurofeedback has been successfully applied to central nervous system problems, such as symptoms of traumatic brain injury, stroke rehabilitation, fibromyalgia, depression and other mood and anxiety disorders, attention, hyperactivity, explosiveness/anger, and learning problems. Controlled studies on neurofeedback have been and are being conducted.

**Effects of Neurofeedback:** Neurofeedback tends to make functioning clearer and easier. It has increased cognitive functioning (memory, concentration, attention, ability to learn and to read, organizing, and sequencing), motivation (initiating and completing activities), and motor skills (coordination, balance, grace, recovery from paralysis). It has elevated mood as an antidepressant. It has improved sleep at night and reduced sleepiness during the day. It has increase energy and stamina. It has reduced seizures, explosiveness, irritability, spasticity, and background anxiety. It has reduced migraine and fibromyalgia pain as well as restless legs problems.

**Side Effects:** Although no significant side effects have been observed so far, the ones that we have seen will be discussed with you by your neurofeedback practitioner; and your understanding of them will help you work with us to provide successful treatment. The side effects sometimes seen with neurofeedback are in the form of *temporary* increases of the symptoms you already have. If you experience side effects, let your neurofeedback practitioner know so that he/she can work closely with you to make adjustments. This is done the same way medications are adjusted by your physician.

**Medical Stability:** You must be medically stable to engage in this treatment. Please tell your therapist if you have any changes in medication as these changes may impact your central nervous system stability. At times, improved nervous system stability may require reducing your medication. This, however, should only be done in consultation with your prescribing physician. Do not make medication changes without the advice and consent of your prescribing physician.

**Other treatments:** Other forms of neurofeedback treatment can have roughly the same effects and side effects. No comparative studies have been conducted to permit objective evaluation of which is better and under what conditions. It is also important to note that no two brains function exactly the alike and individuals differ in their responses to almost any form of treatment, medication or otherwise. We may suggest the need for other forms of treatment to help enhance the effect of the neurofeedback training.

# DOTSON CONSULTING AND COUNSELING, INC

---

**Discontinuing treatment:** You may discontinue treatment at any time for any reason. Should you wish to discontinue treatment, please inform your therapist. He or she will cooperate and provide copies of any records for another therapist.

**Privacy:** Your treatment records are private to the fullest extent of the law; that is, except in cases of potential harm to yourself or others, or in civil or criminal proceedings and with a court order.

**Payment:** At this time payment for neurofeedback services is not reimbursed through your insurance company. All services are \$55 per session and payment is due at the time of service rendered.

*Because people are individuals, success with neurofeedback is best predicted with a complete evaluation and the development of a treatment plan. The evaluation allows us to predict which symptoms will respond, and which may respond first. And, as with any treatment, there can be no guarantee of success in any particular instance. You are therefore invited to consent to be treated on the basis of this information. Before you give your consent to be treated, we want you to ask as many questions as are necessary for you to understand this process. Please continue to express your questions, observations, and concerns at any time during the treatment process.*

## **Consent to Treatment:**

I have been informed of the potential effects, side effects, benefits and risks of this treatment and give my consent to participate in it.

---

Signature of client/guardian

---

Date