NEW CLIENT INFORMATION

Name_____ Date of Birth_____

Address_____

City/State/Zip_____

Phone (home)_____ (work)_____ (cell)_____

E-mail_____ Occupation_____

EMERGENCY CONTACT

Name_____ Phone_____

Relationship to Client_____

PARENT OR GUARDIAN OF MINOR

Name_____

Address_____

City/State/Zip_____

Phone (home)_____ (work)_____ (cell)_____

E-mail_____ Occupation_____

PRIMARY SYMPTOMS OR DIAGNOSIS_____

REFERRED BY_____

PHYSICIAN

Name_____Specialty_____

City_____ State_____ Phone_____

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

PAYMENT AGREEMENT:
You are responsible for the services provided by Neurotopia LLC at the time of service.

INSURANCE REIMBURSEMENTS:
You are responsible for payment at the time of service and for submitting claim forms to your insurance company. On your request, we will supply you with statements containing information needed by your insurance company.

Please note that we may release information required by your insurance company to process your claim. While we will attempt to maintain an appropriate level of confidentiality, we have no control over the information once it leaves our office. Insurance companies should keep your information confidential. However, you may wish to check with the company providing coverage about their confidentiality policies.

APPOINTMENT SCHEDULING AND CANCELLATION POLICY:
We ask your cooperation in maintaining a schedule and keeping appointments.
We ask that you please provide at least 24-hour notice if you need to cancel an appointment. Other clients might be able to fill a cancelled appointment time. You may be charged the full session fee if we do not receive a 24-hour notice of cancellation. We recognize that there are times when emergencies arise, and we ask your cooperation in notifying us as soon as possible when your plans change.

REQUEST:
We serve many chemically sensitive clients, so we ask that you refrain from using fragrances when coming to this office. Your cooperation is greatly appreciated.

Signature of Client (or responsible party) _____ Date_____

Printed Name_____

CONFIDENTIALITY / MANDATED REPORTER STATEMENT

Although treatment is designed to be confidential, some staff members are licensed clinicians and health providers, who by the nature of their license have specific criteria for when confidentiality can and must be breached. While confidential information can normally be released by Neurotopia LLC only when there is a written release from the client, there are the following exceptions:

> Personnel are mandated reporters for a reasonable suspicion of child, dependent or elder abuse. If such a suspicion arises, they are mandated to report it to the authorities. Confidentiality can and must be breached when clients present a danger to themselves or others (suicide or homicidal ideation). While it is their legal responsibility to report, it is also their ethical responsibility to help negotiate such a crisis. Intent to destroy property may also be cause for breaching confidentiality. When treatment records are under a court subpoena, records and confidential communications can also be breached.

I hereby consent to treatment under the terms and limitations as described in this document.

Signature_____Date_____

INFORMED CONSENT

Neurotopia LLC offers EEG (brain wave) biofeedback training to clients in connection with a variety of conditions that appear to be associated with dysregulation of brain activity, including hyperactivity and attention deficits, behavior problems, sleep disorders, depression, anxiety, chronic pain, brain injury, seizures, and other conditions. EEG biofeedback training is also provided for clients who wish to enhance brain regulation for improved performance.

The staff at Neurotopia are not physicians. The staff is made up of licensed or certified and non-licensed or non-certified personnel with expertise in various health related professions. They are aware, by experience and through the literature, of beneficial effects of the kind of biofeedback they offer, including remediation of attention deficits and hyperactivity, recovery from some of the consequences of brain injury, and the reduction of incidence and severity of seizures. Scientific investigation is ongoing to determine the mechanism by which these benefits are achieved. At present, Neurotopia staff recommends the training based on empirical observations of improvement in clients with similar conditions.

No guarantee is made that any individual client will improve with training. It is possible that for a few clients who do experience benefit, the improvement may fall off after the cessation of training. Those individuals would benefit from periodic follow-up or booster sessions. The training appears to be a harmless procedure as far as is known at present. No injuries are known in the experience of Neurotopia, or in the literature reviewed. It is a non-invasive procedure. Nevertheless, beyond this, Neurotopia does not make any representation concerning the safety or efficacy of training. Any questions should be addressed to the prospective client's physician. The client should continue ongoing therapies until otherwise advised by a physician.

It is the client's responsibility to monitor the subjective effects of training and to continue training so long as benefit is perceived. The research literature indicates that there are some individuals who are apparently unaffected by the training. Accordingly, Neurotopia encourages the client to evaluate progress after about ten sessions to determine if further training is indicated. Neurotopia invites discussion at this point, or at any point in the training.

By signing this form, the client indicates his/her understanding of the principles set forth here and waives any claim of damages due to the training, including worsening of the client's condition for which the training was undertaken, claimed side effects, or the failure to improve with training. In addition, the client agrees to take full responsibility for his/her training, the benefit of such training, or the lack thereof, and further agrees to hold Neurotopia LLC harmless from all claims associated with such training.

If there is a need to speak directly with your primary care practitioner, or if we need further information (reports, tests, etc.), we will request that you sign a release of information allowing us to have that communication. The client further agrees that the data obtained in connection with the EEG biofeedback may be used by Neurotopia LLC in publications, with the protection of the privacy and preservation of the anonymity of the client. The client agrees to submit any dispute with Neurotopia LLC to binding arbitration under the rules of the American Arbitration Association.

Signature of Client (or responsible party) _____ Date _____

Printed Name_____

Neurotopia

Neurotopia LLC

20300 Vanowen St, Apt #33,
Winnetka, CA, 91306

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this facility has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this facility at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by these restrictions.

Patient Name: _____ **DOB:** _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's/guardian's signature on this Notice of privacy Practices Acknowledgement Form, but was unable to do so as documented below:

Date: _____ Name: _____

Reason: _____

_____

_____

rev 10/03