GEORGETOWN
PSYCHOLOGY ASSOCIATES

INFORMED CONSENT FOR NEUROFEEDBACK

I authorize *Georgetown Psychology Associates* to provide neurofeedback training to me and / or my child _____.
(Print Client or Child's Name)

I understand that this training is used for a variety of conditions that appear to be associated with irregular brain activity, including but not limited to ADHD, depression, anxiety, stroke and seizure disorders. Neurofeedback, or EEG biofeedback, is being offered as a form of psychological treatment that offers potential benefits for the area of difficulties in which I am seeking help. Training is recommended on the basis of clinical observation of improvement in clients with similar conditions.

I have been informed that at the present time neurofeedback is not widely accepted as a conventional or traditional treatment approach and may be regarded by many practitioners and insurance companies as an experimental treatment.

I understand that EEG biofeedback requires the placement of surface electrodes on my scalp for the purpose of recording my EEG and using this signal to provide feedback in the form of video display or games. The techniques used to attach the electrodes have been used at numerous clinics and research institutions for many years, and no deleterious side effects have been reported. I understand that I can remove the electrodes at any time if I so desire. There is no risk of electric shock from this procedure.

I have been informed that the training is noninvasive, and no injuries or permanent negative effects have been reported in the literature. I am aware of the need to inform my clinician if I have a personal or family history of epilepsy/seizures or bipolar disorder, as neurofeedback can occasionally lower seizure threshold in individuals with vulnerability to seizures or initiate a manic episode in individuals who are vulnerable to bipolar disorder.

I understand also there may be some temporary effects that result in some degree of discomfort or disequilibrium. Some individuals have reported that treatment seemed to produce a temporary worsening of some symptoms, including feeling more anxious or distractible, or have reported temporary headaches, sleep disturbances, or similar difficulties. These reactions are usually limited in time and can be resolved by changing training protocols. I agree that I will contact Georgetown Psychology Associates should the degree of discomfort be such that I do not wish to wait until the next scheduled feedback session to have it addressed.

I understand that some individuals have reported that training may affect the body's response to medications. I understand that I should not stop or alter any of my medications without consulting my physician/psychiatrist. I should continue ongoing therapies until otherwise advised by the physician. Should new symptoms develop, it is my responsibility to inform my health care providers, including my neurofeedback practitioner.

I understand that it is my responsibility to monitor the subjective effects of training. Neurofeedback protocols are developed based on the client's report after each session related to behavior and feelings after the sessions, as well as from the initial, weekly, and monthly evaluations. Successful training depends on this feedback. The client is encouraged to evaluate progress after 10 to 20 sessions to determine if further training is indicated.

By signing this form, I indicate my understanding of the principles set forth here and hereby authorize *Georgetown Psychology Associates* to provide me with neurofeedback treatment.

_____	_____	_____
Name of Client or Parent (PRINT)	Signature of Client or Parent	Date
_____	_____	_____
Name of Witness (PRINT)	Signature of Witness	Date