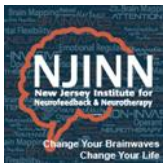

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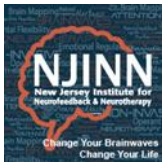
CONSENT FOR TREATMENT

The purpose of this form is to obtain your voluntary consent to participate in one or more methods of assessment and/or treatment, and to disclose potential risks associated with this type of therapy/treatment.

☐ QEEG Brain Mapping/Assessment

Electroencephalography (e-lec-tro-enceph-a-lo-graphy ~ EEG) is a neurological assessment procedure that records the changes in electrical potentials (brainwaves) in various parts of the brain. By recording the electrical activity of the brain from the scalp, EEG images the brain by taking measures with both eyes closed and eyes opened; and may also be done while the patient is performing a cognitive task. This allows for detection of the location and magnitude of brain activity involved in the various types of cognitive functions. Images are acquired by placing a cap with electrodes on the head or by using individual electrodes to monitor the amount of electrical activity at different points on the scalp. Quantitative Electroencephalography (QEEG) is the measurement, using digital technology, of electrical patterns at the surface of the scalp which primarily reflect cortical activity or "brainwaves". A multi-electrode recording of brain wave activity is recorded and converted into numbers by a computer. These numbers are then statistically analyzed and are converted into a color map of brain functioning.

The QEEG mapping system used for this mapping is the New Mind Magnitude Analysis System. The Magnitude Analysis System provides a reference database system that provides simple output indicating whether EEG is high or low in the various dimensions of analysis. QEEG consists of placing a cap with electrodes/sensors on the patient's head, and ear clips on each ear lobe. Each site will first be cleansed and electrode paste/gel will be placed under each sensor to insure proper conductivity to read the patient's brainwaves. The recording is done while the patient is sitting in a chair. The patient is asked to relax with eyes closed and a second set of measures is taken with eyes opened. Preparation takes approximately 15 minutes and the actual EEG recordings take about 5 minutes.



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Physcotherapist

QEEG measures will involve the use of the BrainMaster® software and hardware including a BrainMaster® Discovery 24E unit as well as an Elctro-Cap® with electrodes, and Electrogel®® and/or 10/20 Electrode Paste®. Areas where sensors/electrodes may be placed will be prepped withNuPrep® and/or an alcohol prep pad.

NOTE: In order to participate in neurofeedback, patients are required to have a QEEG. In other instances, to help verify a disorder, we may recommend that the patient have a QEEG. The benefits of QEEG include but are not limited to assessing overall brain function that includes magnitude (power) connectivity (brain functioning) and asymmetry (the balance of certain brain waves). In addition the QEEG will produce an analysis of cognitive functioning, an emotional analysis, a list of supplements that may be deficient and a list of metabolic categories. QEEG helps assess the patient's need for specialized treatment. There are generally no risks involved with QEEG. In some cases patients may feel anxious about having the procedure done. There are no known side effects. QEEG provides an analysis of brain functioning. Alternative methods of determining brain functioning include but are not limited to psychological and neurological testing, Medical EEG, MRI, fMRI, brain scans including CAT and SPECT. The risks associated with not having a QEEG are that the individual may not have a complete understanding of possible issues.

PLEASE NOTE: QEEG cannot be used for diagnostic purposes; however, it may be used for differential diagnosis.

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☐ Biofeedback / Peripheral Biofeedback

Biofeedback is a non-invasive form of treatment. Sensors or electrodes are attached to the body and these sensors provide a variety of readings –feedback– which is displayed on the equipment for the patient to see. The signals typically measure what are thought of as involuntary body functions (see paragraph below) and/or brainwave function. With this information, patients can learn to make changes so subtle that at first they cannot be consciously perceived. With practice, however, the new responses and behaviors can help to bring relief and improvement to a variety of disorders. Biofeedback is a term that covers a variety of modalities including peripheral biofeedback (i.e., heart rate, blood pressure, skin response, breathing rate, muscle tension, body temperature), and EEG Biofeedback or neurofeedback (brain wave biofeedback).

The application of computer software and hardware, and homework exercises (i.e., relaxation and meditation techniques) are used to help the patient. Biofeedback is continuously subjected to rigorous study and evaluation by the international medical and mental health communities.

Peripheral Biofeedback training will involve the use of one or more of the following: RET, HRBVP, a stress thermometer, HeartMath® (EMWave) software and hardware, a Pulse Oximeter, and or Resperate®. Sensors may be placed on the fingers, ear lobes, waist, skin, or forehead. Areas where sensors may be placed will be prepped with an alcohol prep pad.

The risks of Peripheral Biofeedback may include uneasiness in learning and viewing one's vital signs, and frustration when learning proper biofeedback techniques. Biofeedback will not interfere with most other treatments. The patient may feel tired/sleepy or physically "heavy" as a result of participating in

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Biofeedback. It is also possible that the patient might fall asleep during or after Biofeedback sessions. The risks of not participating in biofeedback include continuation of presenting problem and/or symptoms. Alternative treatments to biofeedback include, mental health counseling, neurofeedback, CES, AVE, medicines, alternative health care options (i.e., acupuncture, natural supplements), physical therapies and other additional medical treatments and procedures.

☐ Neurofeedback / EEG Biofeedback / Neurotherapy/ Bioneurofeedback/ ROSHI/HEG

Neurofeedback is a treatment technique that presents the patient with real-time feedback on brainwave activity, as measured by sensors on the scalp, typically in the form of a video display and sound. When brain activity changes in the direction desired by the neurofeedback protocol, a positive "reward" feedback is given to the patient. Rewards/reinforcements can be as simple as a change in pitch of a tone or as complex as a certain type of movement of a character in a video game. The characteristic that distinguishes neurofeedback from other biofeedback is a focus on the central nervous system and the brain. Neurofeedback has its foundations in basic and applied neuroscience as well as data-based clinical practice. It takes into account behavioral, cognitive, and subjective aspects as well as brain activity. Several electrodes/sensors are placed on the scalp and earlobes. The sensors detect brain wave activity including Delta, Theta, Alpha and Beta. Individual brainwaves are measured and revealed on a computer screen in order to see brainwave activity. The patient learns to train down or train up certain brainwaves. Treatments last from 10-30 minutes and may occur two or more times per week for a minimum of 30-40 sessions. For some conditions, such as Autism, 80-100 or more sessions may be required in order to determine benefits from neurofeedback. Neurofeedback consists of placing one or more electrodes on the patients scalp and ear clips on one or both ear lobes. Each electrode site will first be cleansed will be prepped with NuPrep® and/or an alcohol prep pad. Electrodes will be attached

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to the scalp using 10/20 Electrode Paste. The patient sits in a reclining chair and is asked to relax with eyes closed while listening to sounds or tones; or with eyes opened while watching visual stimuli on a computer monitor and listening to sounds, tones, music or sound tracks to videos. Preparation takes approximately 10 minutes and the actual neurofeedback sessions take anywhere between 15 – 30 minutes, or more in some cases. Neurofeedback treatments will involve the use of the BrainMaster® software and hardware including a BrainMaster® Atlantis 4X4, Brainmaster Discovery 24E, as well as electrodes, and 10/20 Electrode Paste®.

NOTE: In order to engage in neurofeedback, you will first be required to have a neurological assessment (QEEG). It is also important to understand that many neurofeedback protocols are considered to be experimental.

The risks of neurofeedback include increased dreaming and recollection of dreams, nightmares, boundary clarification (relationship changes), an occasional headache, and moodiness.

Neurofeedback will not interfere with most other treatments. The patient may feel anxious as a result of participating in neurofeedback and seeing their own brain activity, or may feel tired/sleepy or physically "heavy" as a result of participating in neurofeedback. Temporary shifts in mood may occur as a result of neurofeedback training. It is also possible that the patient might fall asleep during or after neurofeedback sessions.

The risks of not participating in neurofeedback include continuation of presenting problem and/or symptoms. Alternatives to neurofeedback include mental health counseling, peripheral biofeedback, medicines, alternative health care options (i.e., acupuncture, natural supplements), physical therapies and other additional medical treatments and procedures.

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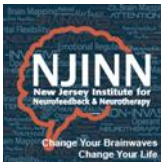
☐ **Holistic Health**

The above treatments cannot help the patient's brain make neurotransmitters, if the building blocks for them are not present in the blood stream. Therefore, it is very important for the patient to eat a balanced diet while in treatment, and that includes the major amino acids, vitamins, minerals, and other micronutrients. It's important that you are well hydrated as it is necessary for electrical conductivity in the body. It is advised that patients not consume any alcoholic beverages the same day as treatment.

In addition to eating a healthy diet, it is important to participate in routine exercise and establish a routine sleeping pattern (i.e., going to bed approximately the same time every night and getting up approximately the same time every morning). A minimum of 7-8 hours of sleep per night is strongly recommended.

Choosing Treatment

None of the above treatments are mandatory. The patient will not be pressured to enter treatment, nor for not participating in treatment. The patient may withdraw from/stop any of the above treatments at any time without consequence.



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Physcotherapist

Patient Name:_____ **Date Of Birth:_____/_____/_____**

Consent for Treatment

I voluntarily consent to participate in and undergo the treatment methods and modalities checked and initialed below, and hereby release Honey Sterzer, New Jersey Institute for Neurofeedback and Neurotherapy and its counselors, therapists, technicians, independent contractors, and other employees from any and all liability which may occur in connection with the above mentioned treatments/therapies.

I understand that I am free to withdraw my consent and to discontinue participation in the treatment modalities/methods checked below, at any time. I have been informed that the professional staff working with me are not medical doctors, but are specially trained personnel. The natural consequences and potential risks and benefits have been fully explained to me by Honey Sterzer. I have checked and initialed the treatments I wish to participate in below:

Neurological QEEG Assessment Signature _____

Peripheral Biofeedback Signature _____

Cranial Electrotherapy Stimulation (CES) Signature _____

Audio Visual Entrainment (AVE) Signature _____

Neurofeedback Signature _____

Cognilight Signature _____

Vielight Signature _____

My signature below indicates that I have discussed the procedures/treatments I am consenting to with my treating professional. I have read the Consent for Treatment form; or I have had the form and its contents read to me (or my legal guardian) and explained to me. My signature below indicates that I am voluntarily consenting to assessment and/or treatment as described in this form. I understand I may ask questions at any time, and may request to stop treatment at any time.

_____ _____

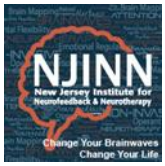
Patient Signature **Date**

_____ _____

Parent/Guardian (if patient is under 18) **Date**

_____ _____

Clinician Signature **Date**



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Patient Name:_____ **Date Of Birth:_____/_____/_____**

Neurofeedback Pretreatment Review

Neurofeedback is a method of neurophysiological regulation training, with the goal of reducing symptom severity over time, not a quick fix or cure. On average most people require approximate 15 sessions to begin to experience anticipated changes.

Metabolic or Chemical factors may interfere with progress, so certain tests may be recommended early in your treatment plan such as genetic testing, blood or saliva tests, hair or stool analysis and other tests depending on the presenting issues that may block your progress.

Along with testing, changes in your diet, sleeping habits, use of electronics and other lifestyle changes may be recommended.

If currently on medication please let your prescribing physician know about your neurofeedback program and keep them updated of any changes as you train.

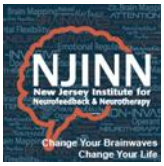
You are expected to complete a symptom tracker to help us assess your progress and modify your program as needed.

When participating in neurofeedback two training sessions per week is recommended. Early withdrawal from neurofeedback may result in incomplete changes or lack of consolidation and thus result in minimal benefit from neurofeedback treatment. Post treatment mapping is recommended.

Outcomes and side-effects that may occur during a neurofeedback session, after a neurofeedback session, and/or in-between neurofeedback sessions may include:

-Sleep differences, improved quality of sleep
-Nightmares
-Reduced emotional reactivity
-Enhanced calmness
-Enhanced Focus
-Improved Attention
-Emotional lability/Moodiness
-Reduced ability to resist emotions
-Increased awareness of dreams
-Boundary Clarification (relationship changes)
-Increased energy level
-Headaches generally improve
-Improved Concentration
-Memory improvement
-Irritability
-Increased anxiety and agitation

Generally, when neurofeedback is not resulting in positive changes and benefit to the individual, it is often the result of the following confounds: metabolic issues, family/work system stressors, and/or poor nutrition and exercise. We may need to investigate these issues and work together on a strategy to address these concerns. By signing below you are agreeing to follow through with the above recommendations and that you understand the information presented on this form.



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_____ _____

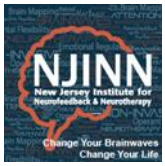
Patient Signature **Date**

_____ _____

Parent/Guardian (if patient is under 18) **Date**

_____ _____

Clinician Signature **Date**



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Physcotherapist

Patient Name:_____ **Date Of Birth:_____/_____/_____**

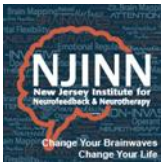
NJINN and Honey Sterzer RN, LCSW is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check and initial each person/entity that you approve to receive information	**Description of information to be released** Check and initial each that can be given to the person/ entity on the left in the same section.
□Voice Mail	□Results of QEEG /Assessments □NFB Treatment Sessions □Other
□Spouse (provide name & phone number)	□Results of QEEG /Assessments □NFB Treatment Sessions □Other
□Parent (provide name & phone number)	□Results of QEEG /Assessments □NFB Treatment Sessions □Other
□Other (provide name & phone number	□Results of QEEG /Assessments □NFB Treatment Sessions □Other
□ I give permission for a letterhead with NJINN's return address to be sent to my residence or business	□Results of QEEG /Assessments □NFB Treatment Sessions □Other
□ My email: □Other E-mail: Name of Person E-mail will go to:	□Results of QEEG /Assessments □NFB Treatment Sessions □Other

Patient Information: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Patient Signature **Date**



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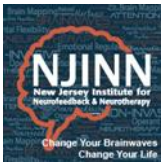
Physcotherapist

Parent/Guardian (if patient is under 18)	**Date**
Clinician Signature	**Date**



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Patient Name:_____ **Date Of Birth:_____/_____/_____**

Email/Data Consent Form

This is to inform you of the Data Communication policy of NJINN and staff. All reasonable efforts are made to keep your email and telecommunications secure and confidential. If you choose to email NJINN with confidential information, then you are giving informed consent for reciprocal email communication between our staff and you. Consenting to communicate confidential information via email means that you accept any potential risk associated with a breach in confidentiality and remove any liability from NJINN and staff. Please note that text message communications are not a secure form of data. If you choose to communicate via text you accept any potential risks associated with a breach in confidentiality and remove any liability from NJINN.

Please Sign Next to the Options You Choose:

_____ I do wish to communicate confidential information via email.

_____ I do not wish to communicate confidential information via email.

_____ I do wish to communicate confidential information via text.

_____ I do not wish to communicate confidential information via text.

_____ I do wish to have voice mail messages left on my phone.

_____ I do not wish to have voice mail messages left on my phone.

_____ _____

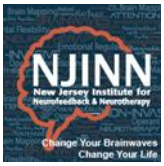
Patient Signature **Date**

_____ _____

Parent/Guardian (if patient is under 18) **Date**

_____ _____

Clinician Signature **Date**



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Physcotherapist

Authorization for Release of Information (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and report any grievance.

The health insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

We have prepared this "Summary Notice of PIPPA Privacy Practices" to explain how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A notice of HIPPA Privacy practices containing a more complete description of the uses and disclosures of your health information is available to you upon request.

We may use and disclose your medical records for each of the following purposed: treatment, payment, and health care operations:

TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. PAYMENT means such activities such as obtaining reimbursement for services, billing or collection activities and utilization review. HEALTH CARE OPERATIONS include the business aspects of running our laboratory service practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide laboratory draw site information or other health-related services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required by honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected healthy information, which you can exercise by presenting a written request.

1. You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment, and health care operations. You may also request that we limit our disclosures to persons assisting your care. We will consider your request, but are not required to accept it.
2. You have the right to request that you received communications containing your protected health information from us by alternative means or at alternative locations. For examples, you may ask that we only contact you at home or by mail.
3. Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a nominal fee for copying and mailing.

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4. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.
5. You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment before April 15, 2003 among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

Patient Name:_____ **Date Of Birth:_____/_____/_____**

My signature below indicates that I have read the information/forms listed below and/or have had them explained to me and understand the information provided in them:

1) ***Authorization for Release of Information (HIPAA)***
2) ***Informed Consent***
3) ***Neurofeedback Pretreatment Review***
4) Email/Data Consent Form

_____ _____
Patient Signature **Date**

_____ _____
Parent/Guardian (if patient is under 18) **Date**

_____ _____
Clinician Signature **Date**

Contact Information:
Honey Sterzer, RN, LCSW, Psychotherapist
New Jersey Institute for Neurofeedback and Neurotherapy
Address: 317 Cleveland Avenue
Highland Park, NJ, 08904
Phone: (732) 249-9800
Email: NJbraintrain@gmail.com
Web Site: http://www.njinn.com