The Office of
FONDA HART, LMFT
Licensed Marriage and Family Therapist
CA License # LMFT 39053
6042 N. Fresno Street, Suite 101, Fresno, CA 93710
559-801-1430

CONSENT FOR BRAINPAINT NEUROFEEDBACK

Introduction

This agreement is intended to provide you with important information regarding the policies of Fonda Hart, LMFT (herein "Therapist") and to clarify the terms of the therapeutic relationship between the neurofeedback provider (herein "Provider") and the client (herein "Client"). Any questions or concerns regarding this Agreement should be discussed with Fonda Hart prior to signing it.

About Neurofeedback

Brainpaint neurofeedback has been available to the public for about 20 years. Research has been done by several universities, including Harvard and UCLA; numerous studies have been published demonstrating its efficacy.

In order for neurofeedback to be effective, Best Practices requires a minimum of two sessions per week. Sessions less than twice weekly are not recommended. If you are unable to commit to, and participate in at least two sessions per week, it is best to wait until you are able to commit and follow through. Individual outcomes cannot be guaranteed. 95% of people experience short-term improvement, 5% of people find no benefit. A few clients may experience short-term side effects, which are reversible within a few days or with a subsequent session. No long-term or permanent side effects have been reported. The gains made during the neurofeedback process are generally permanent.

Session Payment and Insurance

Payment for sessions are due in full at the time of Client's session. Payments can be made by cash, check, Venmo or card payments.

Neurofeedback may or may not be a covered benefit with your insurance policy. Fonda Hart is not a contracted provider with any insurance company. Therapist's office can verify benefits upon request. If neurofeedback is a covered benefit with your insurance, a superbill or visit statement will be provided for Client to submit. Alternatively, Therapist is generally willing to courtesy bill, upon request. Regardless of insurance coverage, ***Client is responsible for full payment of all session fees.*** Reimbursement will be between Client and Insurance company.

If Client does not pay the balance in full, and Therapist has attempted unsuccessfully for 3 months to collect the balance owed, Client will be referred to a collections agency to recover the unpaid balance. When referral to Collections is made, adjustment or fee reductions will be reversed, and all sessions will be invoiced at full fee.

I understand that I am fully responsible to Therapist for all charges, including unpaid charges by insurance or any other third-party payor.

Initials: _____

24 Hour Cancellation Policy

In the event that Client needs to cancel a session, Provider is to be notified at least 24 hours in advance. Client is responsible for payment of session fee for any missed sessions if 24-hour notice was not given. Insurance does not reimburse for missed or late-cancelled sessions.

I understand that I am responsible to pay for missed sessions and late-cancelled sessions.

Initials: _____

Confidentiality

Services provided, and any information disclosed by Client, are generally confidential and will not be released or disclosed to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder, and dependent adult abuse; reporting a serious threat of violence toward a reasonably identifiable victim, or reporting risk of self-harm for intervention.

Although Therapist has an encrypted E-mail system, Client should be aware that E-mail is not as secure as telephone. Client assumes the risk for any violation of confidentiality that occurs in the course of E-mail or text communication. E-mail or text communication can be used for scheduling and other logistical needs, but not for actual treatment.

Initials: _____

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed any questions with Therapist and has had his/her concerns addressed to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in Brainpaint neurofeedback. Client has a right to discontinue neurofeedback sessions at any point. Therapist maintains the right to terminate the treatment process if warranted.

_____ _____

Client Name (*Please Print*) Date

_____

Signature of Client (*or Authorized Representative*)

_____

Parent or Guardian Name (*For Minor, Please Print*)

_____

Signature of Parent or Guardian (*For Minor*)

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