Neurofeedback Consultation Waiver

I fully understand that Dr. David Silvers is a medical doctor licensed in the state of Florida to perform and treat neurological conditions. In addition, Dr. Silvers studied neurofeedback and in the context of the neurofeedback session, he is acting in the capacity of a neurology specialist.

I recognize that the services provided by Dr. Silvers, and his team at Find Your Mind, are in the context of a neurofeedback consultation and are within the parameters of neuro-modulation.

Dr. Silvers uses neurofeedback EEG for mapping and diagnostic information, plus therapies and medical management, related to various neurological conditions and symptoms. In this case, Dr. Silvers is acting in the context of a neurofeedback consultant and not as my attending neurologist, unless a special appointment was made and billed for to retain his consultation services.

I have solicited Dr. Silvers' professional services in good faith, exercising my free will and following the dictates of my own conscience, which allows me to select what I understand to be beneficial to my health. I am seeking counsel for conditions that fall under Dr. Silvers' neurology training and expertise.

I understand that neurofeedback is the process of training the body and its unconscious systems to react differently once trained properly. This is a non-invasive process which is using EEG frequencies to map and retrain brain waves. Initial consultations may take over 90 minutes to ensure proper history taking and performance of mapping and cognitive testing. Follow up sessions will start at 2-3 times a week and then subside to once a week and eventually settle on once a month with more or fewer sessions as needed. The best results will be with me coming not fatigued, well fed and well hydrated which will maximize the benefit of the neurofeedback sessions.

Patient's Name: ________________________________ Date:_____________ DOB: _________________

List medications:_____________________________ List Allergies:______________________________

____ ____

____ ____

____ ____

Are you pregnant? Y N

Do you have a pace maker? Y N

Are you a diabetic? Y N

Do you have seizures? Y N

Do you suffer from epilepsy? Y N

Do you have photosensitivity? Y N

Patient's Signature: ____________________________________

Neurofeedback Informed Consent

Gardens Neurology offers neurofeedback therapy, through Find Your Mind, to patients requesting such services. This training is offered to adults and children, either self-referred or as recommended by a physician, to treat conditions shown to be responsive to such training. These conditions are generally thought to be those that are associated with irregular brain activity where there is also research and clinical evidence to suggest neurofeedback as a viable treatment.

Our healthcare staff has education, training and experience in neurofeedback and in EEG technology in addition to neurology. We recommend neurofeedback on the basis of our observations of improvement in patients with similar conditions. **We do not guarantee a cure since this is a training process, not a treatment. This is not intended to diagnose, treat cure or prevent any disease.** However, test results indicate that more than 80% or patients receiving neurofeedback improve on at least one test scale and more than half improve on three out of four scales. Some may find that the improvement is not permanent and may benefit from regular follow-up sessions. Some may not experience any effects at all from the training initially therefore requiring an adjustment in their individual protocol. The protocol can be adjusted at any time but still does not guarantee improvements 100% of the time. Neurofeedback has been researched and studied for over 30 years and appears to be harmless with no reported injuries or side effects.

If you have received neurofeedback in the past, we are not able to transfer the information over and will need a new brain map that was conducted and performed on our system. Only with the brain mapping information that was conducted here, can our system put together the perfect protocol for you and execute it during your training. We are happy to review your past test results, but unfortunately, cannot transfer the information over with the idea of continuing treatment that started elsewhere.

By signing this form, you are indicating that you understand the information presented above.

If you are suffering from seizures, epilepsy or visual photosensitivity, please notify us prior to staring the neurofeedback training.

____

O Yes, I understand and agree to the terms of this document

O Yes, you may administer the neurofeedback training

Patient's name: ___________________________________ DOB:_____________ Phone #:_____________

Signature: ____ Date:__________________

Guarantor Name (if guarantor is not the patient):___________________________ Signature: ________________________

Neurofeedback Financial Responsibility Form

Thank you for allowing us to treat you with neurofeedback. As payment for these services are required, you are obligated to ensure payment of our fees in full prior to starting treatment. Although some services may be covered, you are ultimately the one who is responsible for verifying benefits and for payment of your final/entire bill. Since most insurance companies do not reimburse for neurofeedback, payment in full is expected for brain mapping and each package of sessions . We urge you to check with your insurance company regarding your benefits and we are glad to provide you with the medical codes if you choose to submit a claim through your carrier. Please remember that your insurance policy is a contract between you and your insurance company therefore you should find out what is available through your network.

We understand that there may be times when you miss an appointment due to various circumstances. However, we urge you to call our office more than 24 hours prior to your appointment time if you need to reschedule your appointment. Failure to do so will result in charging for the session you missed.

I, the undersigned, acknowledge that I will pay for my neurofeedback sessions in advance and will comply with the terms stated above. I understand that neurofeedback is not a cure that helps 100% of recipients and agree to use all my sessions before deciding whether it was beneficial or not. If I choose to stop treatment at any time, I understand that the remaining sessions are non-refundable. Any unused sessions are good for one (1) year.

I have read the above policy regarding my financial responsibility to Find Your Mind by Gardens Neurology, for providing services to me or the named patient below. I promise to pay in full any amount due as a result of these services. This financial responsibility form supersedes any prior writings which are now null and void and are no longer in effect.

Patient Name: ____ Date: ____________________________________

Patient Signature: ____ Phone #:__________________________________

Guarantor Name: ____ Guarantor Signature:_________________________