Authentic Healing and Counseling
9432 Katy Freeway, Suite 400, Houston, TX 77055
Phone: 713-376-9500 Fax: 713-391-8421
Email: Info@AuthenticHealingAndCounseling.com

CONFIDENTIAL REGISTRATION and NEUROFEEDBACK TRAINING PACKET

This information is to help us better understand you and your situation.
Please fill it out as completely as you can. All information will be held in strict confidence.

CLIENT INFORMATION: **DATE:** _____

Name: _____ Date of Birth: _____ / _____ / _____

Address: _____City: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

Gender: ☐ Male ☐ Female Preferred language: _____Referred by: _____

Marital Status: _____Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐I decline to specify

Race: ☐American Indian ☐Asian ☐Black/African American ☐Pacific Islander ☐White ☐I decline to specify

INSURANCE INFORMATION (Skip if self pay):

Primary Insurance: _____Phone: _____

Employer: _____Name of Subscriber: _____ DOB: _____ / _____ / _____

Policy ID #: _____Group #: _____ SSN: _____ - _____ - _____

Secondary Insurance: _____Phone: _____

Employer: _____ Name of Subscriber: _____ DOB: _____ / _____ / _____

Policy ID #: _____Group #: _____ SSN: _____ - _____ - _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to Patient: _____

Address: _____City: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

1.) I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with Authentic Healing and Counseling.
2.) AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the release of any information regarding my condition or treatment to insurance company.
3.) AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

_____ _____

Patient / Legal Guardian Signature **Date**

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PRIMARY DOCTOR INFORMATION AND CLIENT HISTORY:

Name: _____ May we contact him/her? ☐Yes ☐No

Phone: _____ Fax: _____

1.) Why did you decide to come or why were you referred to counseling? _____

_____

2.) Have you sought counseling in the past? ☐Yes ☐No
If you answered yes, please provide details here: _____

_____

3.) Have you been treated in an inpatient facility or hospital for any mental disorder or substance abuse issues? ☐Yes ☐No. If you answered yes, please provide details here: _____

_____

4.) Are you currently taking any medication? ☐Yes ☐No
If you answered yes, please list current medications and medications tried in the past 12 months here:

_____

Please check all concerns that apply to you:

Relationship Problems:
- ☐ Friendship Problems
- ☐ Verbal conflicts
- ☐ Trust issues
- ☐ Sexual problems
- ☐ Marital conflict
- ☐ Martial distances
- ☐ Suspicious about other people

Eating Problems:
- ☐ Excessive dieting
- ☐ Low body weight
- ☐ Overeating
- ☐ Vomiting after eating
- ☐ Using laxatives
- ☐ Oversensitive about eating

Employment Problems:
- ☐ Employment termination
- ☐ Long-term unemployment
- ☐ Difficult boss
- ☐ Co-Worker difficulties
- ☐ Overwhelmed with too many duties
- ☐ Working too many hours

Lifestyle Problems:
- ☐ Gambling
- ☐ Goals not being met
- ☐ Financial troubles
- ☐ Debt
- ☐ Decision-making

Sleep Disturbance:
- ☐ Insomnia
- ☐ Sleeping too much
- ☐ Nightmares
- ☐ Snoring
- ☐ Acting out dreams

Mental Disorder:
- ☐ Anxiety/Panic
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Psychosis
- ☐ Other _____

Other Problems:
- ☐ Procrastination
- ☐ PMS
- ☐ Menopause
- ☐ Menstrual problems
- ☐ Physical problems
- ☐ Impulsivity

- ☐ Unable to relax
- ☐ Shyness
- ☐ Thinking/confusion
- ☐ Low motivation
- ☐ Financial trouble
- ☐ Guilt

- ☐ Self-harm (cutting/scratching)
- ☐ Hair pulling
- ☐ Parenting
- ☐ Mixed feelings
- ☐ Indecision
- ☐ Substance/Alcohol abuse

5.) Please provide other pertinent information here that will help me better understand your situation so that I can come up with a more suitable treatment plan for you:

I certify the information provided is correct and I authorize services to be provided to the above-named patient:

_____ _____

Patient / Legal Guardian Signature **Date**

AROUSAL ASSESSMENT FOR NEUROFEEDBACK

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Name: _____

Under Arousal (C3)

- ○ ADD diagnosis
- ○ Poor concentration
- ○ Inattentive
- ○ Distractibility
- ○ Frequent daydreaming
- ○ Spaciness/fogginess
- ○ Forgetful
- ○ Confused thinking
- ○ Lack of motivation
- ○ Depression/low mood
- ○ Lethargy
- ○ Sensitive/feelings easily hurt
- ○ Tears easily
- ○ Low self-esteem
- ○ Tends to introversion
- ○ Excessively shy
- ○ Frequent waking at night
- ○ Not feeling rested after sleep
- ○ Sleep > 9 hours/night
- ○ Falls asleep in low stimulation situations
- ○ Snores without apnea
- ○ Likes caffeine
- ○ Dislikes alcohol effects

Over Arousal (C4)

- ○ Busy mind/many competing thoughts
- ○ Impulsive
- ○ Fidgety
- ○ Hyperactive
- ○ Easily bored
- ○ Risk seeker
- ○ Impatient
- ○ Agitated
- ○ Aggressive
- ○ Angry depression
- ○ Anxious/fearful
- ○ Tense
- ○ Feel overwhelmed
- ○ Frequent tension headaches
- ○ Teeth grinding or clinching
- ○ Holds resentments
- ○ Many social conflicts
- ○ Difficulty falling asleep
- ○ Sensory overload
- ○ Low emotional awareness
- ○ Heart palpitations
- ○ Dislikes caffeine
- ○ Likes alcohol effects
- ○ Menopausal hot flashes

Unstable Arousal (C3-C4)

- ○ History of head seizures*
- ○ History of head injury*
- ○ Migraine headaches*
- ○ Bipolar symptoms or dx*
- ○ Chronic fatigue symptoms
- ○ Wakes during night – light sleeper
- ○ Sleep apnea
- ○ Sleepwalking – now or as child
- ○ Frequent nightmares
- ○ Bedwetting after conventional age
- ○ Night sweats
- ○ Hot flashes, not related to menopause
- ○ Psychiatric illness in family
- ○ PMS symptoms
- ○ Relationship issues – diagnosed with personality disorder
- ○ Poor eye contact

Instability items marked with (*) "trump" other indicators regardless of number of items for under or over arousal.

Protocols for underarousal typically involve beginning with 15-18 Hz reward, 2-8 inhibit (targeted to spectral display), and 22-36 Hz inhibit.

Protocols for overarousal typically involve beginning training with 12-15 Hz reward, 2-6 Hz inhibit (targeted to spectral display), and 22-36 Hz inhibit.

Protocols for unstable arousal typically involve beginning training with 12-15 Hz reward, 2-6 Hz inhibit (targeted to spectral display), and 22-36 Hz inhibit. Reward may need

Training should be conducted in proportion to the number of items in each category indicated by client. For example, if there are twice as many underarousal symptoms as overarousal, train both C3 and C4 but using twice the number of periods at C3 compared to C4. If instabilities are present, conclude each session with C3-C4 training. Reward and inhibit frequencies should be adjusted based on client response.

I certify the information provided is correct and I authorize services to be provided to the above-named patient:

_____ _____

Patient / Legal Guardian Signature **Date**

SETTING NEUROFEEDBACK GOAL

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Name: _____

What do you intend to do? Where do you intend to go? I will know my therapy is working when: (List 3)

1. _____
2. _____
3. _____

List three (3) things you are not doing now but would like to be doing:

1. _____
2. _____
3. _____

List three (3) things you are doing now that you would like not to be doing:

1. _____
2. _____
3. _____

Do you have any childhood traumas? ☐Yes ☐No If so please explain: _____

_____

_____

Have you or do you have posttraumatic stress disorder? ☐Yes ☐No

Do you have digestive issues? ☐Yes ☐No Diarrhea: ☐Yes ☐No Constipation: ☐Yes ☐No

Are you sensitive to Light? ☐Yes ☐No Are you sensitive to Sound? ☐Yes ☐No

Do you have drug sensitives? ☐Yes ☐No Do you have dyslexia? ☐Yes ☐No

I certify the information provided is correct and I authorize services to be provided to the above-named patient:

_____ _____

Patient / Legal Guardian Signature **Date**

GENERAL INFORMATION AND PROCEDURES

Authentic Healing and Counseling
Reveling In The Authentic You

This form provides information about our counseling relationship, procedures involved, and your authorized consent to treatment.

Length of Session: Sessions are scheduled for 45-50 minutes.

Cancellations: Your session time is reserved for you and is taken seriously. **Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged. You will be charged $75.00 for no shows and late cancellations.**

Fee Structure: The client is financially responsible for payment of fees, which will be collected at the time of service. The client will also be responsible for any portion of fees not reimbursed of covered by health insurance. In the event of an accrued balance, the client and therapist can negotiate a payment schedule.

Confidentiality: Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony requires by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is as minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

Client Privacy: Recent laws have been enacted for client privacy. It is important to know that emails and mobile phone conversations are not secure or guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone, there is a potential for confidentiality to be comprised.

Counseling Approach: To get the most of counseling of therapy, it is important to assume responsibility for your experience. Therapists can only help you based on the information you provide. If you are like most people, you probably have some sensitive issues you are not comfortable discussing with others. Those are usually the things you most need to talk about with your therapist. Regular, consistent participation in treatment sessions, as well as any "homework" assignments will help facilitate the process, but no therapist can ethically guarantee achievement of your goals. Please feel free to ask questions about the process and let your therapist know if you are not satisfied with how it is progressing. Because of the nature of the therapeutic process, you may experience periods of emotional discomfort on the way to your goals. No single therapist is the best one for every client. If you do not feel your therapist is the right fit for you, we will be happy to help you with another referral in this or another office. You are free to discontinue treatment at any time. Gina Baiamonte MS, LPC recommends to notify her in advance, when the client is ready to end the counseling relationship, a closing session, for a healthy relationship closer.

As a client, I have read, understood and agree to the terms and conditions of the information presented in this form as I enter into therapeutic process.

_____ _____

Patient / Legal Guardian Signature **Date**

Informed Consent for Neurofeedback Training

I hereby authorize *Authentic Healing and Counseling* to provide me with neurofeedback training.

I understand that this training is used for a variety of conditions, which appear to be associated with irregular brain activity, including but not limited to ADHD, depression, anxiety, stroke and seizure disorders. Training is recommended on the basis of empirical observation of improvement in clients with similar conditions.

I understand that EEG biofeedback (neurofeedback) requires placement of surface electrodes on my scalp for the purpose of recording my EEG and the use of this signal to provide video displays and audio signals.

I understand that some individuals have reported that training may affect my body's response to medications for my condition and for unrelated conditions. 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 the client's own responsibility to monitor the subjective effects of training. Neurofeedback is based on the input of the client's report from day to day sessions as well as from the initial evaluation and depends on the full participation of the client i.e. his/her feedback about the effects of the training. The research literature indicates that there are some individuals who are apparently unaffected by training. Accordingly, the client is encouraged to evaluate progress after about ten sessions to determine if further training is indicated. Discussion is invited at this point or any time during the training.

No representation is made that any individual client will improve from training. There is some indication that some client's improvement may fall off after the cessation of training. These individuals would benefit from periodic follow-up or booster sessions. The training is non-invasive and appears to be a harmless procedure as far as is known at present. No injuries are known or reported in the literature.

By signing this form, I indicate my understanding of the principles set forth here and waive any claim of damages due to the training including worsening of my condition for which the training was undertaken, claimed side effects of the failure to improve with training and submit any dispute with Authentic Healing and Counseling to binding arbitration under the rules of the American Arbitration Association.

Date _____ Signature_____

Printed Name_____

Release of Information

I agree that _____ may consult with the client's primary care

practitioner _____ or specialist _____
with regard to the EEG training and obtained results.

Signed_____ Date_____

Printed Name_____

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No Show and Pre-Authorized Charge Form

I authorize Authentic Healing and Counseling to keep my signature on file and to charge my Credit Card listed below for:

- **The one-time amount of $75.00 in the event that I fail to cancel my scheduled appointment and failed to provide 24-hour notice.**
- **45-50 minutes Counseling Sessions**
- **Neurofeedback Sessions**

I understand that this form is valid for on-going visits unless I cancel the authorization through written notice to the service provider.

Customer Name: _____

Cardholder Name: _____

Card Type: ☐Visa ☐MasterCard ☐Discover ☐American Express

Account Number: _____

Expiration Date: _____ Card Verification Number: _____

Cardholder Signature: X_____ Date: _____

USE OF PRE-AUTHORIZED CHARGE FORMS

This form is a pre-authorization to charge credit card payments to your clients. You must sill complete the actual credit card charges, including getting an authorization from each transaction.

The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1.) The cardholder will be charged for:
   - **a.** Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
   - **b.** Recurring charges of a specific amount, to be charged on a scheduled-bases between two designated dates.
   - **c.** A total fee, of a designated amount to be charged to the customer's card one time. (Missed appointment fee)

2.) Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's date does not extend beyond the "ending date" for any recurring charges.

3.) The cardholder must sign and date the form.

4.) The form is valid for on-going visits unless the cardholder cancels authorization through written notice to the service provider.

NOTICE OF PRIVACY PRACTICES

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.

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. "HIPAA" provides penalties for covered entities that misuse personal information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care options.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement of activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

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

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and 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 to 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 health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Client Rights/Confidentiality services will be rendered in a professional manner consistent with accepted legal and ethical standards. Information about you that is obtained during counseling sessions will not be revealed to anyone else without your consent except where disclosure is required by law. These instances include:

- Where there is reasonable suspicion of physical/sexual abuse to children or elderly persons
- Where you present a serious danger to yourself or others
- Where a court orders the counselor to disclose information
- If at any time for any reason you are dissatisfied with our services, please let us know. We also reserve the right for consultation with other professionals whenever believed necessary.

We are required by law to maintain the privacy of your protected health information and to provide you with notice on our legal duties and privacy practices with respect to protected health information. (Continued on page 6)

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
US Dept. of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & 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.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Client Name/Guardian: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment of this notice but was unable to do so as documented below:

Date:	Initials:	Reason: