Holistic Child Psychiatry, LLC
Holistic Adult Psychiatry

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INFORMED CONSENT FOR SWLORETA NEUROFEEDBACK

I am executing this informed consent document ("informed consent") to verify and confirm my discussion with Provider regarding the risks, benefits, and alternatives to treatment through swLORETA Neurofeedback

I understand that I am a participant in the decision-making process and I am free to decline services or treatments at any time, including after treatment or services have begun. I understand that I may revoke this consent at any time before or during treatment.

I agree to bring to the attention of practice's clinical staff, if, at any time, I have any lack of understanding of such risks, benefits and alternatives, and inquire of clinical staff for further explanation until I have a full understanding before giving consent to this specific treatment or procedure.

swLORETA Neurofeedback

RISKS

I understand that, as with any health treatment, swLORETA Neurofeedback is not without risk. Potential risks of this treatment include, but are not limited to:

- **Anxiety**, **Social anxiety, Depersonalization**
- **Cognitive impairment**, **Brain fog** .
- **Chattering teeth**, **Trembling, Internal vibrations, Vocal changes**
- **Fatigue**, **Tiredness, Low energy, Dizziness**
- **Depression**
- **Headaches, Head pressure**
- **Muscle tension**
- **Worsening of symptoms**

may provide benefits I understand that other side effects and risks may occur.

BENEFITS
I understand the thought process behind why Provider has suggested this particular treatment. I understand that, in general, swLORETA Neurofeedback mayimprove symptoms and functioning for the following conditions:

- Stroke, Brain injury including aneurysm or concussion, seizure disorders
- ADHD, Autism spectrum disorder

- Anxiety, PTSD (post-traumatic stress disorder), depression
- Sleep problems
- Parkinson's disease
- Eating disorders, Addiction disorders
- Migraines, Chronic pain
- though no particular outcome can be warrantied or guaranteed.

ALTERNATIVES
As alternatives, Provider encourages me to speak with and consider the advice of other providers, including conventional or mainstream physicians and providers. In addition to discussing other modes of therapy that may be used for the treatment of my condition, Provider and I have discussed, and I understand, the possibility of a referral to a specialist for my condition(s) if I have not already consulted with an appropriate specialist.

I also understand that one alternative to this treatment is to refuse this particular treatment and to seek alternative treatments with Provider or Practice, or to refuse this particular treatment without seeking alternatives with Provider, Practice, or any other providers.

NOTE: Do not sign this form unless you have read it and feel that you understand it. Ask any questions you might have before signing this form. Do not sign this form if you have taken medications which may impair your mental abilities or if you feel rushed or under pressure.

By signing below, I acknowledge and certify that I have had opportunities to ask questions and have had them answered to my satisfaction; I have read and fully understand the foregoing Informed Consent, and I have all of the knowledge I currently desire; I have discussed the issues noted above with Provider; and I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

PATIENT

SIGNATURE: _____

PRINT NAME: _____

TITLE (if legal representative or guardian): _____

DATE: _____

I have explained this Informed Consent and answered all questions in layman's terms, and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed, comprehends the information, and has consented.

PRACTICE

SIGNATURE: _____

PRINT NAME: _____

DATE: _____