Client Demographics

Client Info:

Full Name: _____

Address: _____

_____

Mobile Phone: _____

Home Phone: _____

Email: _____

Preferences:
- ☐ When contacted, do not mention nCenter name
- ☐ Do not contact by phone call
- ☐ Do not contact by text messages
- ☐ Do not contact by email

Birth Date: _____

*Social Security Number: _____

Employment: ☐ Employed ☐ Unemployed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ With Disability

Employer: _____

Marital Status: _____

Gender: ☐ Male ☐ Female ☐ Other ☐ Transgender M-F ☐ Transgender F-M

Primary Care Physician: _____

Emergency Contacts:

Full name: _____ Phone #: _____ Relationship: _____

Full name: _____ Phone #: _____ Relationship: _____

Primary Insurance:

Insurer: _____

Insured's ID Number: _____

Group Number: _____

Client's Relationship to Insured: _____

Required if not Self:

Insured's Full Name: _____
(Name on card)

Insured's Phone #: _____

Insured's Birth Date: _____

Insured's Address: _____

_____

Bill to:

Full name: _____

Date of Birth: _____ Relationship: _____

Address: _____

_____

Phone #: _____

*Required Card on File:
If you have questions, please see our billing specialist
EXCEPTION: Medicaid

☐ Credit Card ☐ Debit Card ☐ HSA or MSA

Name on Card: _____

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

CC Number: _____

Expiration Date: _____ Security Code: _____

I have completed this form honestly and to the best of my ability and have read and understand the information provided regarding counseling and neurofeedback. I, or parents/guardians of the above named client, give my consent for treatment.

Client/Guardian Signature: _____ Date: _____

Client/Guardian Signature: _____ Date: _____

☐ I am the sole parent or guardian of this minor child

nCenter Counseling & Neurofeedback

Confidential

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/ confusion
- ☐ Sadness/ depression
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Fatigue
- ☐ Recurring, disturbing memories
- ☐ Change in appetite
- ☐ Withdrawal from people
- ☐ Anxiety/ worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Racing thoughts
- ☐ Wide mood swings
- ☐ Suspicion/ paranoia
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Defiance
- ☐ Aggression/ fights
- ☐ Homicidal thoughts
- ☐ Frequent arguments
- ☐ Irritability/ anger
- ☐ Peer/ sibling conflict
- ☐ Stealing
- ☐ Destroys property
- ☐ Running away
- ☐ Swearing
- ☐ Curfew violations
- ☐ Lying
- ☐ Manipulative behavior
- ☐ No/ few friends
- ☐ Eating problems
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Toileting problems
- ☐ Fire setting
- ☐ Work/ school problems
- ☐ Legal problems
- ☐ Sexual behavior
- ☐ Computer addiction
- ☐ Alcohol/ drug use
- ☐ Lack of motivation
- ☐ Other: _____

Rank the three most pressing concerns in order:

1. _____ 2. _____ 3. _____

Please write a short description of the concern bringing you into counseling at this time:

_____

_____

Does your child have any existing medical problems or current physical symptoms? If so, describe:

_____

Parent Signature: _____ Date: _____

nCenter Counseling & Neurofeedback

QEEG AND NEUROFEEDBACK/ NEUROMODULATION INFORMED CONSENT

The nCenter uses a quantitative electroencephalograph (qEEG) brain map as a diagnostic tool to direct counseling, to help determine neurofeedback and neuromodulation protocols, and to measure treatment outcomes.

The nCenter uses two neurofeedback and neuromodulation systems: NeuroField and Low Energy Neurofeedback Systems (LENS).

The NeuroField system includes a pulsed electromagnetic field (pEMF) stimulation device that is designed to reduce stress and relax the human body. It has also been registered with the FDA as a 510K exempt medical device. It has undergone electrical safety testing with Underwriter Laboratories and has met the 60601-safety standard as a medical device. Preliminary studies show that pulsed electromagnetic field stimulation of the brain is effective in reducing the symptoms of depression, anxiety, ADHD, TBI, Parkinson's disease and others. The NeuroField system also includes: Transcranial Direct Current Stimulation (tDCS), Transcranial Alternating Current Stimulation (tACS), Transcranial Random Noise Stimulation (tRNS), and Real-Time Z Score (RTZ) brain training. The pEMF and the tDCS/tACS/tRNS/RTZ can be used together or in stand-alone mode.

Most people who use NeuroField have no side effects. Since 2008 over 50 licensed healthcare professionals have evaluated the NeuroField effect which has resulted in the following affects:

Occasionally some people report becoming 'wired' or 'tired'. A person may feel an abundance of energy or may feel compelled to sleep after a treatment. We advise you not to operate heavy machinery or drive a motor vehicle immediately after treatment. Most people who have this side effect feel it within an hour after treatment. The effect is usually short lived and resolves itself in one to two hours.

NeuroField can cause capillary dilation which can feel like a headache. This effect usually resolves itself within one to two hours after a treatment. This effect has not been reported to last longer than 24-72 hours. Should this occur longer than 72 hours please notify us and your physician.

NeuroField is not intended for the following individuals: those with a seizure disorder, women who are pregnant, people with pacemakers, or people that have any metal attached to or inserted on or in the head. Additionally, you are responsible for notifying staff if you use an insulin pump and where it is located so that protocols can be adjusted accordingly. NeuroField is also not recommended for anyone with the flu, a cold or any type of acute bacterial infection.

People with a history of PTSD or a significant mood disorder may have an abreaction or may respond with intense mood changes. We encourage these individuals to seek counseling alongside NeuroField.

NeuroField can have an impact on medication effectiveness making them stronger and more potent. Most people who take medication respond with no problems to NeuroField treatment. However, it has been reported that people who take blood thinners have experienced a more potent effect from the medication.

The LENS is an FDA-certified Class II medical device that involves measuring and recording brain-wave frequencies, and then using the recorded frequency measurements to create a feedback signal. The feedback signal is a set of electromagnetic pulses that return your brain signals to you at an offset. In contrast to other brainwave biofeedback procedures, LENS does not maintain that faster brainwaves are better for some issues, or that slower brainwaves are better for others. Rather, LENS supports the brainwaves becoming quieter at rest and more flexible in their functioning when at work.

It has been documented that LENS and NeuroField can cause insomnia, fatigue and sleepiness, but this has been observed in a very small population.

In clinical use, LENS training has been observed to significantly help with problems associated with depression and anxiety, post-traumatic stress disorder, and traumatic brain injury and with specific symptoms of anger, fear, sleeping problems, loss of energy, and lack of motivation.

However, more research is needed to substantiate and validate observations about either NeuroField or LENS.

I understand that all protocols and services associated with NeuroField and LENS are considered experimental. At this time the nCenter is not aware of any long-term negative consequences from the use of NeuroField or LENS. Should the nCenter become aware of any negative effects I will be notified immediately and given options for my minor child or me. Furthermore, if the above-mentioned side effects or any other occur, I understand that I am to inform the nCenter so that modifications can be made to reduce or eliminate these issues. I agree to complete a Neurofeedback Survey each session to document and communicate any positive or negative effects that may be related to my treatment.

I have solicited the nCenter's services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my own or my minor child's health. I give my consent to use the qEEG brain map procedure on my child and/or me. I am requesting that the nCenter provide me with NeuroField and/or LENS treatments. Since NeuroField and LENS are emerging and developing fields, I allow the nCenter to release information associated with my health care issues, diagnosis, and outcomes associated with NeuroField and/or LENS with other NeuroField and/or LENS providers and between clinicians at the nCenter. I understand that the released information to NeuroField and/or LENS providers will be used for research and development of NeuroField and/or LENS and that information released between nCenter clinicians is in support of the nCenter client's well-being. I understand that my personal information that would allow me to be identified will not be released, but that only my gender, age, ethnicity and primary complaints will be disclosed. I understand that I have the right to refuse NeuroField and/or LENS at any time. I understand that I can refuse to release any of my information without prejudice from the nCenter as I have the right to confidentiality.

I have read and understood the contents of this consent document, and hereby give my consent to receive or authorize NeuroField and/or LENS treatment.

Client Name: _____ Age: _____

Client Signature: _____ Date: _____

If client is a minor or is under legal guardianship both parents/guardians must sign:

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Clinician Date

Authorization for Release and Consent

I, _____,

☐ as a client

☐ as a guardian of _____

whose client date of birth is _____ and whose social security number is _____

hereby give my consent to nCenter personnel to release, obtain and exchange information within and among the nCenter staff, nCenter contracted professionals and the following individuals, referring organization or provider:

Client's Physician _____

Referring Organization/Provider _____

Other Individuals/Providers _____

Records to be exchanged may include psychiatric/psychological testing and/or initial (clinical) evaluations, progress notes, referrals, medical and social information, counseling plans, neurofeedback protocols, qEEG brain map results and discharge summaries, or other essential information.

I understand that these records are protected under HIPAA and Federal Confidentiality Regulation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this consent will expire two years from the date listed above. I also understand that I may revoke this authorization with a written request prior to the expiration. I understand that the revocation will not apply to information that has been released in response to the authorization prior to my written request for revocations. I further understand that my records may be transmitted by FAX to the above name(s).

_____ _____

Signature of Client Date

If client is a minor or is under legal guardianship both parents/guardians must sign:

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Clinician Date

Information and Service Agreement

This agreement is designed to inform you about the nCenter and our professional relationship with our clients. If you have any questions after reading this, please feel free to discuss them with your counselor. Each counselor is licensed by the state of Montana as a Clinical Professional Counselor or Social Worker. We do not testify in court unless mandated, nor do we provide psychological testing for child custody cases.

As we work together, we need to assess the process. We invite mutual reevaluation as we go along. It is impossible to guarantee specific results regarding your goals. However, we assure you that our services will be rendered in a professional manner consistent with accepted ethical standards.

In the unlikely event of your counselor's incapacitation, serious illness, or death, your records will be available to you for transition to a new counselor.

APPOINTMENTS:
Appointments are usually scheduled for the same time each week. Your appointment is reserved for you, and you are financially responsible for the scheduled time. In the event you will not be able to keep an appointment, please call the nCenter at (406) 599-2492 at least 24 hours prior to your scheduled appointment. IF NOTICE IS NOT GIVEN, LATE CANCELS AND MISSED SESSIONS WILL BE BILLED. Exceptions will be made where there are extenuating circumstances.

CONFIDENTIALITY:
We keep confidential anything said with the following exceptions: you authorize disclosure of your records through a signed release of information; your counselor determines that you are a danger to yourself or others; we become aware of suspected child or elder abuse, we are ordered by a court of law to disclose information; or you authorize release of medical information to your insurance company as detailed below. We regularly consult with other professionals to enhance the services you receive. In the case consultation process, no identifying information is shared and professionals with whom we consult are bound by ethical and legal obligation to maintain confidentiality. An additional HIPAA (Health Insurance Portability and Accountability Act) Privacy Practice Information Form is available for you upon request. We recognize that technology imposes risks on confidentiality and we endeavor to comply with Section H of the ACA Code of Ethics.

PHONE CALLS-EMERGENCIES-THERAPIST ABSCENCE:
Our office phone number is (406) 599-2492. Messages are checked regularly. If no one can be reached and your call is an emergency, you may call 911 to receive emergency assistance or you may call the Help Center at (406) 586-3333.

PAYMENT FOR SERVICE:
Clients are required to have a payment card on file (credit, debit, HSA or MSA). Any accrued balance will be invoiced to you monthly. At that time, you may choose to pay by any method, however if no payment is received within 30 days we will charge your card on file. Please notify the nCenter if a difficulty arises regarding the cost of your therapy impacting your ability to make timely payments. Payment plans are available. Should an account remain unpaid with no prior arrangements, after 30 days an interest rate of 18% will begin to accrue. Defaulted accounts may be sent to collections. There will be a $20.00 fee charged for any returned checks.

COST FOR SERVICE:
Counseling sessions are billed as follows: Intake, $140; 60-minute session, $135; 45-minute session, $95; and a 30-minute session, $70. Neurofeedback Intensives are $100 per session and are not covered by insurance. Individuals in counseling receive complementary neurofeedback at no extra charge. QEEG Brain Maps are $597.40 and their Interpretations are $525.

Talk with our billing specialist if you have any questions regarding your insurance company's coverage of these services. Late canceled appointments and no shows will be billed at the regular rate.

BILLING:
We use a billing service to provide prompt and professional handling of claims. The service is bound by strict confidentiality requirements. If you do not wish to have your account recorded with this service, or if you do not wish to have your insurance billed, please notify us immediately. If you choose not to use the billing service, you will be responsible for paying the total fee at the time services are rendered. If requested, we will provide you with the necessary receipt so that you can submit to your insurance company for reimbursement.

INSURANCE:
Our billing service will submit insurance claims at your request. You are still responsible for payment of the deductible and/or co-payment amount at the time services are rendered. You are responsible to be at all of your sessions on time and leave on time as your insurance will be billed for the amount of time you have scheduled. You will also be responsible for payment if the insurance company for any reason refuses coverage for services. Billing your insurer requires the release of a diagnostic code. Some insurance companies additionally require further details, such as information to support diagnosis, treatment goals and progress toward goals. The insurance carrier is responsible to HIPAA confidentiality. If you have questions or concerns about this process, please discuss these concerns with us.

If you have any questions, feel free to ask. Please sign and date this form to indicate that you have read, understand and agree to the information and terms of office policies and professional practice. A copy of this information is available to you upon request. Your signature authorizes the release of HIPAA compliant information necessary to process your insurance claims and direct payment by your insurance company to us.

I have read and understood the contents of this consent document, and consent to receive services from the nCenter.

Client Name: _____ Age: _____

Client Signature: _____ Date: _____

If client is a minor or is under legal guardianship both parents/guardians must sign:

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

Clinician Signature: _____ Date: _____