Neurohealth
BRAIN TRAINING CENTER

Client Financial Responsibility Agreement

We appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment of any charges not covered by your insurer, payment of any deductibles, co-pays and co-insurances as determined by your contract with your insurance carrier.

Commercial Insurance Carriers

You are required to present a valid insurance card at every visit and as needed throughout care. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. Any outstanding balances, co-payments and deductibles are due prior to checking into your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of filing the claim, fees are due and payable in full from you. We understand that sometimes our clients may experience financial difficulties. If this should be the case, please communicate with our Financial Manager so that we may assist you in making payment arrangements. A $25.00 late fee will be incurred for any past due balances.

Co-Pay & Co-Insurance Policy

If your health insurance carrier requires you to pay a co-pay for services rendered, your payment is expected and appreciated at the time of service at each visit. If your co-insurance coverage is 50% or greater, we require a down payment prior to services being rendered.

Medicare

Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System) as well as secondary insurances that do not crossover. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered services will be due at the time services are rendered.

Self-Pay Policy

In the event that (1) you do not have health insurance, or (2) you know in advance that a specific service will not be covered by your insurance company, or (3) Neurohealth is not contracted and does not submit claims on your behalf, you will be responsible for payment prior to services rendered on the date of service at Neurohealth and agree to pay the full and entire amount at each visit.

Terms of Payment

Neurohealth requires a credit card on file to process payments. Payment is expected within 15 days of statement date. Any balances beyond 60 days will be referred to an outside collection agency. In the event that your account is turned over for collections then the client or responsible party agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

Cancellation/No-Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, there will be a $245 charge if you cancel or are a no show within 72 hours prior to the New Client Evaluation appointment. You will incur a fee for missed appointments of $50.00 for each clinician visit and $85 for each neurofeedback session) if you have not notified Neurohealth within 24 hours prior to your appointment time.

I have read, understood and agreed to the above financial policy for payments of professional fees.

SIGNATURE _____ DATE _____

PRINTED NAME _____

P: 630-969-3ADD (3233)
F: 630-969-3310

Client Information

Personal Information

FIRST NAME | MIDDLE | LAST

STREET ADDRESS | CITY | STATE

DATE OF BIRTH | AGE | GRADE | HANDEDNESS ☐ L ☐ R | GENDER ☐ M ☐ F

HOME PHONE | CELL PHONE | EMAIL

Employer Information

EMPLOYER NAME | EMPLOYER PHONE

EMPLOYER STREET ADDRESS | EMPLOYER CITY | STATE | ``ZIP

Responsibly Party for Payments

RESPONSIBLE PARTY NAME | PHONE

ADDRESS | CITY | STATE

EMAIL

Insurance Information

PRIMARY INSURANCE COMPANY

POLICY HOLDER | RELATIONSHIP | POLICY HOLDER DOB

ID NUMBER | GROUP NUMBER

POLICY HOLDER EMPLOYER | PHONE NUMBER

Emergency Contact information

NAME OF EMERGENCY CONTACT

EMERGENCY CONTACT STREET ADDRESS | CITY | STATE

I, the undersigned, certify that information provided above is accurate to the best of my knowledge and that I assign the insurance benefits directly to Neurohealth Associates. I further understand that I am fully responsible for any and all financial balances resulting from insurance non-covered services, co-payments, and co-insurance. I authorize Neurohealth Associates to release my medical information to secure payments from the insurance. I authorize Neurohealth Associates to use the attached credit card information and my signature on file to secure remaining balances. I understand that it is my responsibility to provide contact information where I may be reached at all times as certain tests may require urgent attention.

NAME | DATE

SIGNATURE

Client Information (continued)

Doctor Information

NAME | PHONE | FAX

PHYSICIAN'S STREET ADDRESS

CITY | STATE | ZIP

Other Clinicians & Anyone Involved In My Care

NAME | PHONE ☐ SEND MY RESULTS/TREATMENT PLAN.

NAME | PHONE ☐ SEND MY RESULTS/TREATMENT PLAN.

NAME | PHONE ☐ SEND MY RESULTS/TREATMENT PLAN.

NAME | PHONE ☐ SEND MY RESULTS/TREATMENT PLAN.

How did you find out about us?

☐ DOCTOR ☐ FRIEND/RELATIVE ☐ CURRENT/PAST CLIENT ☐ RADIO/TV ☐ FACEBOOK

☐ GOOGLE ☐ OTHER INTERNET **PLEASE SPECIFY:** _____

Health History Information

Please provide a brief summary of the main symptoms and/or areas of needed improvement:

Past Medication(s): (as applicable)

NAME	DOSAGE	FREQUENCY

Current Medication(s): (as applicable)

NAME	DOSAGE	FREQUENCY

Credit Card Authorization Form

Sign Up For Automatic Payments

Schedule your payments to be automatically charged to your credit card. Recurring payments are convenient, always on time, and eliminate late charges. By completing and returning this form, you authorize regularly scheduled appointment charges to your credit card. A receipt for each payment will be given to you at your next appointment. If for some reason the attempt to charge your primary card fails, we will call you to remind you to update your credit card information. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us prior to the payment being collect.

Credit Card Information

AUTHORIZING PARTY NAME

CARDHOLDER NAME

ACCOUNT NUMBER EXP DATE CVV

BILLING ADDRESS

CITY STATE ZIP

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until the designated expiration date or until I cancel it in writing , whichever comes first, and I agree to notify the business in writing of any changes in my account information or termination of the authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday. I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of the credit card and that I will not dispute payments with my credit card company provided the transactions correspond the terms indicated in the authorization form.

SIGNATURE DATE

Authorization for Release of Information

Personal Information

FIRST NAME | MIDDLE | LAST

STREET ADDRESS | CITY | STATE

PATIENT ID | PHONE NUMBER

☐ **I authorize Neurohealth Associates to release information to...**

NAME OF PROVIDER OR FACILITY

ADDRESS

CITY, STATE, ZIP

PHONE/FAX (INCLUDING AREA CODE)

☐ **I authorize Neurohealth Associates to obtain information from...**

NAME OF PROVIDER OR FACILITY

ADDRESS

CITY, STATE, ZIP

PHONE/FAX (INCLUDING AREA CODE)

The purpose of my request:

☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

Type of record authorized:

☐ Psychiatric, Psychological, Educational Evaluation, and/or Treatment ☐ Medical

Specific information authorized:

☐ Assessments ☐ Progress Notes ☐ Lab Test Results

☐ Diagnostic Impression ☐ Discharge Summary ☐ Treatment Plans

☐ Treatment Summary ☐ Appointment Information ☐ Scheduling/Modifying Appointments

☐ Other (please describe): _____

One-Time Use/Disclosure

☐ I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

My authorization will expire:

☐ When the requested information has been sent/received.

☐ 90 days from this date

☐ Other: _____

Periodic Use/Disclosure

☐ I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

☐ When I am no longer receiving services from Neurohealth Associates.

☐ 1 year from this date

☐ Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Neurohealth Associates, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

SIGNATURE OF CLIENT/REPRESENTATIVE | DATE

☐ Client has been provided with a copy of this authorization.

RELATIONSHIP TO PATIENT (IF NOT THE PATIENT)

STAFF MEMBER PROVIDING COPY

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.

Understanding Your Mental Health Record Information

Each time that you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This i nformation, often referred to as your medical record, serves as the following:

- **Basis for planning care and treatment.**
- **Means of communication among the many health professionals who contribute to your care.**
- **Legal document describing the care that you received.**
- **Means by which you or a third-party payer can verify that you actually received the services billed for.**
- **Tool in medical education.**
- **Source of information for public health officials charged with improving the health of the regions that they serve.**
- **Tool to assess the appropriateness and quality of care that you received.**
- **Tool to improve the quality of health care and achieve better patient outcomes.**

Understanding what is in your health record and how your health information is used helps you to—

+ **Ensure its accuracy** and completeness.
+ **Understand who, what, where, why, and how** others may access your health information.
+ **Make informed decisions** about authorizing disclosure to others.
+ **Better understand the health information** rights detailed to the right.

Your Rights Under The Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:

• **Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations.** "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), § 164.510(a) (for facility directories, but note that you have the right to object to such uses), or § 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

+ **Obtain a copy of this notice of information practices.** Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.
+ **Inspect and copy your health information upon request.** Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access.

You do not have a right of access to the following:

- **Psychotherapy notes.** Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health profes-sional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
- **Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.**
- **Protected health information ("PHI")** that is subject to the Clinical Labo-ratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
- **Information that was obtained from someone other than a health care provider under a promise of confidentiality** and the requested access would be reasonably likely to reveal the source of the information.
- **Information that is copyright protected,** such as certain raw data ob-tained from testing.

In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:

- **A licensed health care professional,** such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
- **PHI makes reference to** another person (other than a health care provid-er) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to ăçţ Ŏĕ Ŏţ ûŎçŦŎŋř Ňçēţ ŎŲŎţ ăŇŲŎŇĕêọĕêŎŲŦģ

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Notice of Privacy Practices (continued)

- **The request is made by your personal representative** and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.

• **Request amendment/correction of your health information.**
We do not have to grant the request if the following conditions exist:

+ **We did not create the record.** If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
+ **The records are not available to you** as discussed immediately above.
+ **The record is accurate and complete.**

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

• **Obtain an accounting of nonroutine uses and disclosures,** those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosures for treatment, payment, and health care operations under certain circumstances, primarily if we maintain an electronic health record. We do not need to provide an accounting for the following disclosures:

+ **To you for disclosures of protected health information ("PHI") to you.**
+ **For the facility directory** or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care of your location, general condition, or death).
+ **For national security or intelligence purposes** under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
+ **To correctional institutions or law enforcement officials** under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
+ **That occurred before April 14, 2003.**

We must provide the accounting within 60 days. The accounting must include the following information:

+ **Date of each disclosure.**
+ **Name and address of the organization or person** who received the protected health information.
+ **Brief description of the information disclosed.**
+ **Brief statement of the purpose of the disclosure** that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

• **Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.**

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

• **Maintain the privacy of your health information,** including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
• **Provide you this notice** as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you. Abide by the terms of this notice.
• **Train our personnel** concerning privacy and confidentiality.
• **Implement a sanction policy** to discipline those who breach privacy/confidentiality or our policies with regard thereto.
• **Mitigate** (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law. These include most uses or disclosures of psychotherapy notes, marketing communications, and sales of PHI. Other uses and disclosures not described in this notice will be made only with your written authorization.

Notice of Privacy Practices (continued)

Examples of Disclosures for Treatment, Payment, and Health Care Operations

- **We may use your health information for treatment.**
  Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions that they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide your physician, other health care professionals, or a subsequent health care provider copies of your records to assist them in treating you once we are no longer treating you. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.
- **We may use your health information for payment.**
  Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.
- **We may use your health information for health care operations.**
  Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.
- **Business associates.** We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010, business associates must comply with the same federal security and privacy rules as we do.
- **Notification.** We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition.
- **Communication with family.** Unless you object, we, as health professionals, using our best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.
- **Research.** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of health information.
- **Funeral directors.** We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.
- **Marketing/continuity of care.** 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. If we contact you to provide marketing information for other products or services, you have the right to opt out of receiving such communications. Contact Rosy at 630-969-3233.
- **Workers compensation.** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- **Public health.** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **Correctional institution.** If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your ealth and the health and safety of other individuals.
- **Law enforcement.** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- **Health oversight agencies and public health authorities.** If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the Department of health.
- **The federal Department of Health and Human Services ("DHHS").** Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

I have read, understood and agreed to Neurohealth's Privacy Policy.

SIGNATURE _____ DATE _____

PRINTED NAME _____

Neurohealth
BRAIN TRAINING CENTER

INFORMED CONSENT FOR TREATMENT
AND NEUROFEEDBACK TRAINING

Emerging Technology Treatment Procedures:
Neurofeedback ("EEG-biofeedback") is an increasingly emerging treatment modality that is currently applied to a wide variety of disorders. Neurofeedback for attention deficit/hyperactivity disorder (ADHD), substance addiction, depression, anxiety, and post-traumatic stress disorder (PTSD) have a reasonably good and increasing research basis for clinical application. A full bibliography outlining the research literature on neurofeedback/neurobiofeedback is available on our website (www.nhahealth.com). Other psychological, neurological, and behavioral disorders, including tinnitus and tremors, have limited published neurofeedback research available, and neurofeedback treatment of these conditions is currently considered to be "experimental." Despite the available literature, neurofeedback for these disorders and many others may be considered "investigational" by some insurance providers. By signing this consent form, you acknowledge your understanding that some applications of neurofeedback are still considered to be in the developmental and emerging stages, and you consent to its use in whole or part of your treatment.

What is involved with the Neurofeedback Treatment Program?
The neurofeedback program requires the completion of one or more of the following assessments: an initial diagnostic interview with Dr. Bonesteel, neurocognitive testing, psychometric testing and brain mapping (also known as a "brain map"). Brain mapping is being utilized not for medical purposes, but to understand regulation (mood, cognition, arousal, etc.). Neurofeedback technicians provide neurofeedback services under the supervision of Dr. Bonesteel.

Neurofeedback training requires the use of computer equipment and the placement of sensors on the scalp and earlobes in order to collect EEG data; this information will be used to provide feedback as to the electrical activity of the brain via auditory signals and visual displays. Some systems capitalize on the brain being reinforced for producing certain brain wave patterns; others capitalize on the brain following a frequency pattern inherent in the technology itself. Just like with any electronic technology and/or devices (e.g., such as computers, Ipods, flat screen TVs, etc) some neurofeedback equipment emit subtle electromagnetic fields similar to the ones we are constantly surrounded by. There is the remote possibility that some individuals may develop skin irritation from the sensor paste or cleaning materials; however, these universally accepted techniques have been used for many years

with no deleterious side effects reported. In addition, there is the uncommon possibility that neurofeedback training can induce some temporary negative side effects (i.e., irritability, fatigue, difficulties falling asleep, etc.). This is exceedingly rare and typically remit once changes in your neurofeedback protocol are made. It is important that you communicate these changes, if any, to Dr. Bonesteel and your neurofeedback technician.

The Importance of Regular Attendance and Participation:
Neurofeedback promotes brain based regulation which requires little, to no, conscious awareness of control. However, consistency of treatment is of utmost importance. Other factors (e.g., maintaining healthy nutrition, etc.) may also enhance the clinical outcome. Treatment may also include other forms of therapy including cognitive-behavioral therapy or cognitive software training.

Physician Consultation and Medication Monitoring:
Because neurofeedback can influence (as well as be affected by) certain types of medication and medication levels, all individuals entering treatment who are currently under the care of a physician are asked to: 1) inform their prescribing physician of their intent to begin neurofeedback and; 2) grant written permission to this facility to contact their physician for medical consultation and monitoring of the effects of the neurofeedback treatment on their physical condition and medication levels. In addition, the patient should immediately inform our clinical staff of any changes in medication (increases, decreases, implementation of new medications) that occur while in treatment. As neurofeedback training progresses, know that over-medication effects can occur. When this happens, a patient must also notify his/her physician that medication adjustments may be needed (often to decrease medication). This will help to ensure that neurofeedback is able to work and to avoid possible over-medication effects such as irritability, hyperactivity, and other potential changes in behavior. We will utilize consultation with other professionals (e.g., neurology, psychiatry, general medicine, pediatrics, etc.) as needed.

Authorization for Treatment:

I hereby certify that I have read and that I fully and completely understand this Informed Consent for Neurofeedback Training, and I have signed this Informed Consent knowingly, freely, and voluntarily. I understand the policies, expectations, and nature of this treatment as explained above. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any neuropsychological. I understand that while my treatment is designed to be beneficial, this facility makes no guarantees about the outcome of this treatment program. I am willing to make a personal commitment to participate to the best of my ability in all steps of the treatment program, though I understand that I am free to withdraw from this treatment at any time. I understand that my failure to comply with my recommended treatment program (such as assignments and regular participation in sessions) could prevent the treatment from

working effectively.

_____ _____
Patient Signature (Guardian signature if patient is a minor) **Date**

_____ _____
Witness (Staff) **Date**

Neurohealth
BRAIN TRAINING CENTER

Patient/Client Code of Conduct Agreement

The Staff at Neurohealth Associates is fully trained to answer all of your questions regarding scheduling and logistics related to the office.

It is of great importance, to all of us, that you be treated with the utmost of respect as demonstrated in our communication style and our willingness to be of assistance.

In turn, ***we ask that you return the same level of respect back to our Staff and our other patients***. This is including but not limited to:

1) Refrain from yelling or raising your voice at any staff member
   INITIAL: _____

2) Refrain from speaking in a confrontational, disrespectful, threatening or condescending tone to any staff member
   INITIAL: _____

3) Refrain from speaking, unsolicited, about personal issues in the waiting room
   INITIAL: _____

4) (If applicable) *As an option*, consider taking children (who are not being seen but are waiting for their sibling to complete their appointment) to the vending area in the basement for a few minutes if they are being disruptive in the waiting room.
   INITIAL: _____

5) We also ask that you be patient if your appointment, for reasons related to patient care, starts after the scheduled time. Please know that our doctors and clinical staff are (behind the scenes) making every effort to respect your time and get the appointment started as soon as possible.
   INITIAL: _____

I have read and understand the above.

_____

SIGNATURE