NEUROFEEDBACK CLIENT,

Welcome to Renovar Wellness and thank you for choosing us for your Neurofeedback Therapy treatment. We look forward to seeing you at your initial visit! In preparation for your appointment, please fill out the attached forms as completely as you can. The more we know about your symptoms and history the better we can choose neurofeedback treatment protocols for you. It helps to know of any past trauma, abuse and drug use, but if any questions make you feel uncomfortable, leave them blank. Once again, please remember that the information that you provide is used for creating the best treatment plan for you and ALL information remains confidential.

You may complete, scan and email these to info@renovarwellness.com or drop them off at our office at least 24 hours before your initial appointment. If you prefer to come early and complete your paperwork, please give us a call at (574) 387-6260 so we can arrange this for you.

The first appointment, will last approximately 60-90 minutes. At that appointment we will give you instructions about setting up additional appointments. After the determined number of initial treatment sessions (typically at least 20), we will discuss your progress and make treatment plan determinations about further appointments.

Also included in this packet information about what to expect during your first appointment. Please read through this so you are prepared for your Brain Mapping Session when you arrive.

Please don't hesitate to contact us if you have additional questions or concerns. We look forward to working with you!

Renovar Wellness Staff

574-387-6260

WHAT TO EXPECT AT YOUR FIRST NEUROFEEDBACK APPOINTMENT:

At Renovar Wellness, we want you to feel comfortable as you begin your Neurofeedback Therapy. During your first appointment, we will review any questions from your Self-Assessment, answer any questions you have and conduct a Quantitative Electroencephalogram (qEEG). A qEEG can sometimes be referred to as a Brain Map. It measures your brain wave activity and any irregular brainwave patterns. This is done by putting a cap with electrodes on your head with a water-soluble gel. There is absolutely NO pain during this process and can even be relaxing for some people. Although the amount gel used for the qEEG is minimal, most people prefer to wash their hair after the appointment.

In preparation for your first visit:

- Get a good night of sleep the night before your appointment
- Fill out the Self-Assessment form and return prior to your appointment
- please bring a list of all medications (prescribed and over the counter) you are taking
- refrain from taking medications until after your appointment
- be sure your hair is completely dry before coming in
- do not use any hair gels, leave in conditioners or extremely sticky hair products the day of your appointment
- refrain from caffeine the day of your appointment
- refrain from alcohol for 24 hours prior to your appointment
- refrain from using any marijuana or CBD products for at least 3 days, or 72 hours prior to your appointment
- refrain from using any prescribed or over the counter stimulants for 72 hrs prior to your first appoinment
- be prepared to provide payment at the time of your visit

If you have additional questions in the coming days before your appointment, feel free to give us a call at (574) 387-6260.

INFORMED CONSENT

Renovar Wellness, LLC offers EEG (brain wave) neurofeedback and biofeedback training to clients in connection with a variety of conditions that appear to be associated with dysregulation of brain activity, including hyperactivity and attention deficits, behavior problems, sleep disorders, depression, anxiety, chronic pain, brain injury, seizures and other conditions. EEG neurofeedback training is also provided for clients who wish to enhance brain regulation for improved performance.

The staff at Renovar wellness, LLC are not all physicians. The staff is made up of licensed or certified and non-licensed or non-certified personnel with expertise in various health related professions. They are aware, by experience, through literature and training, of beneficial effects of the kind of neurofeedback they offer, including remediation of attention deficits and hyperactivity, recovery from some of the consequences of brain injury and the reduction of incidence and severity of seizures. Scientific investigation is ongoing to determine the mechanism by which these benefits are achieved. At present, Renovar Wellness, LLC recommends the training on the basis of empirical observations of improvement in clients with similar conditions.

No guarantee is made that any individual client will improve with training. It is possible that for a few clients who do experience benefit, the improvement may fall off after the cessation of training. Those individuals would benefit from periodic follow-up or booster sessions. The training appears to be a harmless procedure as far as is known at present. No injuries or side effects are known in the experience of Renovar Wellness, LLC or in the literature reviewed. It is a non-invasive procedure. Nevertheless, beyond this, Renovar Wellness, LLC does not make any representation concerning the safety or efficacy of training. Any questions should be addressed to the prospective client's physician. The client should continue ongoing therapies until otherwise advised by a physician.

It is the client's responsibility to monitor the subjective effects of training and to continue training so long as benefit is perceived. The research literature indicates that there are some individuals who are apparently unaffected by the training. Accordingly, Renovar Wellness, LLC encourages the client to evaluate progress after about ten (10) sessions to determine if further training is indicated. Renovar Wellness, LLC invites discussion at this point or at any point during the training

By signing this form, the client indicates his/her understanding of the principles set forth here and waives any claim of damages due to the training, including worsening of the client's condition for which the training was undertaken, claimed side effects or the failure to improve with training. In addition, the client agrees to take full responsibility for his/her training, the benefit of such training or the lack thereof and further agrees to hold Renovar Wellness, LLC harmless from all claims associated with such training.

If there is a need to speak directly with your primary care practitioner or if we need further information (reports, test, etc.), we will request that you sign a release of information allowing us to have that communication. You have the right to terminate training at any time.

Yes, I understand and agree to the terms of this document. Yes, you may administer standard tests.

_____	_____
Name of Client	Date
_____	_____
Signature of Client (or responsible party)	Printed Name
_____	_____
Renovar Staff Signature	Date

Copy of this page provided to client. ☐

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

APPOINTMENT SCHEDULING:
We ask your cooperation in maintaining a schedule and keeping appointments. This is in your best interest for the most effective treatment.

APPOINTMENT CANCELLATION POLICY:
We ask that you provide at least 24-hour notice if you need to cancel an appointment. You may be charged the full session fee if we do not receive 24-hour notice of the cancellation. We understand that emergencies can happen and we ask for your cooperation in notifying us as soon as possible if this happens.

PAYMENT AGREEMENT:
You are responsible for the payment of the services provided at Renovar Wellness, LLC at the time of service. Neurofeedback Therapy session packages are valid for 6 (six) months or 180 days from the time of purchase. Any unused sessions after that time will be forfeited.

RETURNED CHECKS
A returned check charge of $25 will be payable by cash or money order along with the fee for insufficient funds rendered by the bank. A returned check may be cause for providing services on a cash-only basis.

INSURANCE REIMBURSEMENTS:
You are responsible for the payment of services provided at the time of service at Renovar Wellness, LLC. Renovar Wellness does not submit claims to insurance companies for reimbursement. All patients with standard health insurance or other health plans are expected to make payment at the time services are rendered. If you choose to submit a claim to your insurance company, please request a statement from the staff at Renovar Wellness and we provide you with the appropriate information needed to submit to your insurance company.

_____
Printed Name of Client

_____
Signature of Client (or responsible party)

_____
Printed Name if Different than Client

_____
Date

NOTICE OF HEALTH PRIVACY POLICY (HIPAA)

Federal law requires that Renovar Wellness, LLC maintain the privacy of your (or your child's) protected health information and provide you with notice of its legal duties and privacy practices. Our practice may disclose your protected health information only for reasons associated with treatment, payment or health care requirements. Any other use requires written authorization from you. If you believe your privacy rights have been violated, you can contact the Office of Civil Rights, U.S. Dept. of Health and Human Services.

Copy of this page provided to client. ☐

SELF-ASSESSMENT HISTORY FOR NEUROFEEDBACK

Please fill out the attached forms as completely as you can prior to your initial appointment. The more we know about your symptoms and history, the better we can choose the appropriate neurofeedback protocols for you. It helps to know of any past abuse and drug use, but if any questions make you feel uncomfortable, leave them blank. Once again, please remember that the information you provide is used for creating the best treatment plan for you and ALL information remains confidential. Parents, please fill this out for your child if they are receiving treatment and/or assist your older children with this form as you feel appropriate.

The first appointment will last approximately 60-90 minutes. At that appointment we will give you instructions about setting up additional appointments. After the determined number of initial sessions (typically 10-20), we will discuss your progress and make additional treatment plans if indicated.

Thanks for choosing Renovar Wellness for your neurofeedback therapy. We look forward to working with you!

NEUROFEEDBACK ASSESSMENT QUESTIONNAIRE

Today's Date: _____

NAME: _____ AGE: _____ DOB: _____

PREFERRED NAME: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBERS — May we leave a message?

Home: _____ YES NO

Cell: _____ YES NO

Work: _____ YES NO

Email: _____

OCCUPATION: _____ How long? _____

Are you currently in school, attending college or a trade school? YES NO

If yes, where? _____ Area of study/major? _____

How were you referred to our office? _____

Sex: Male Female Prefer not to answer

Dominate Hand: R L Mixed

Why are you seeking Neurofeedback Therapy? _____

_____

_____

_____

_____

Instructions: It is important to know whether you have any of these symptoms presently or have **ever** had them. Please check any that apply to you. Then rate them 0-10.

Scale: 0 = no problem; 10 = serious problem or difficulty for you

ATTENTION SYMPTOMS	X	Rank 0-10	
			ADD (inattentive type)
			Inattention (internal)
			Daydreaming
			Poor Concentration
			Lack of Motivation
			Impulsivity
			Distractibility (external)
			Stimulus seeking (internal)

ATTENTION SYMPTOMS	X	Rank 0-10	
			Thrill seeking
			Competing thoughts; too many thoughts
			ADHD (Attention Deficit/ Hyperactivity Disorder)
			Hyperactivity after sugar
			Hyperactivity after sedatives
			Overwhelmed by stimuli
			Hard to make decisions (executive function)
			Disorganized

SLEEP SYMPTOMS	X	Rank 0-10	
			Night sweats
			Frequent waking during night (without agitation)
			Sleep lightly
			Sleeping too much
			Sleep apnea
			Snoring
			Not rested after sleep
			Waking early
			Physically restless sleep
			Nightmares (bad dreams)

SLEEP SYMPTOMS	X	Rank 0-10	
			Restless leg syndrome
			Vivid dreams
			Clenching jaw
			Waking with agitation
			Sleep walking
			Sleep talking
			Too busy to sleep (manic)
			Teeth grinding
			Night terrors- with screaming, don't remember in the morning

How long does it take you to fall asleep? _____

How many hours of sleep do you get a night? _____

What time do you tend to go to bed? _____

What time do you get up? _____

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EMOTIONAL AND BEHAVIORAL SYMPTOMS	X	Rank 0-10	
			Anxiety
			Depression
			Feelings easily hurt
			Perfectionist
			Remorseful after tantrums
			Rages
			Cries easily (feelings hurt)
			Guilt
			Withdraws when stressed
			Passive
			Posttraumatic stress disorder
			Grumpy
			Borderline personality disorder
			Thinks little of self
			Performance anxiety
			Shy
			Seasonal affective disorder
			Fidgets
			Whining
			Dissociative identify disorder (multiple personalities)
			Loud, unmodulated voice
			Poor eye contact
			Poor social awareness
			Autistic symptoms
			Motor or vocal tics
			Road rage
			Nail biting, nervous habits
			Attachment disorder (history)

EMOTIONAL AND BEHAVIORAL SYMPTOMS	X	Rank 0-10	
			Agitation (upset/emotional more often than not)
			Mania
			Paranoia
			Suicidal thoughts or actions
			Shame
			Compulsive behavior
			Obsessive thoughts
			Involuntary movement or tics
			Impatient
			Aggressive- initiates conflicts
			Jealous/envious
			Angry
			Rumination
			Hates self
			Dissociative
			Lacks empathy
			Lacks cause and effect thinking
			Manipulative, controlling
			Holds a grudge
			Poor comprehension and expression of emotions
			Lack of body awareness (pain, discomfort
			Binge eating
			Anorexia
			Bulimia
			Bipolar (manic-depressive cycles)
			Panic attacks
			Encopresis (soiling)
			Enuresis (bed wetting)

COGNITIVE SYMPTOMS	X	Rank 0-10	
			Dyslexia
			Poor word fluency
			Poor sequential processing
			Poor sequential planning
			Poor reading comprehension
			Difficulty decoding words
			Poor arithmetic calculation
			Indecisive
			Non-verbal learning disabilities
			Poor visual-spatial skills

COGNITIVE SYMPTOMS	X	Rank 0-10	
			Poor sense of self in space
			Poor drawing
			Inability to write neatly (even slowly)
			Poor fine motor skills
			Poor math concepts
			Poor spelling
			Poor tracking during reading
			Lack of prosody in speech (monotone speech)
			Poor sense of direction
			Do not know left from right

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PAIN SYMPTOMS	X	Rank 0-10	
			Chronic pain with depression
			Headache
			Low pain threshold
			Fibromyalgia
			Complex regional pain
			Amplified pain syndrome

PAIN SYMPTOMS	X	Rank 0-10	
			Jaw tension
			Shoulder pain
			Neck pain
			Sciatica pain
			Peripheral neuropathy pain
			Emotional reactivity to pain

NEUROLOGICAL AND MOTOR SYMPTOMS	X	Rank 0-10	
			Tinnitus (ringing in the ears)
			Traumatic brain injury
			Poor balance
			Poor Coordination
			Nervous habits/laugh

NEUROLOGICAL AND MOTOR	X	Rank 0-10	
			Vertigo (dizziness)
			Tremors
			Seizures: if yes, what kind?
			Tics: if yes, what type?

SENSORY INTEGRATION

Do tags on shirts, seams on socks or certain fabrics bother you?	YES	NO
Are you more sensitive to the environment than others?	YES	NO
Do you have an unusual sensitivity to light?	YES	NO
Do you have an unusual sensitivity to certain smells?	YES	NO
Do you have an unusual sensitivity to sounds?	YES	NO
Are you clumsy or accident-prone?	YES	NO

IMMUNE, Endocrine & ANS SYMPTOMS	X	Rank 0-10	
			Immune Deficiency
			Low thyroid function
			Irritability
			Mood swings
			Insomnia
			Migraines
			Racing thoughts
			Autoimmune disorders Describe:

IMMUNE, Endocrine & ANS SYMPTOMS	X	Rank 0-10	
			High Blood Pressure
			Low Blood Pressure
			Severe PMS
			Chronic fatigue syndrome
			Asthma
			Heart Palpitations
			Diabetic controlled by: (circle) Diet Exercise What Type: 1 2 GMD Meds:

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GASTROINTESTINAL SYMPTOMS	X	Rank 0-10	
			Reflux
			Constipation
			Chron's disease
			Ulcerative Colitis

GASTROINTESTINAL SYMPTOMS	X	Rank 0-10	
			Celiac disease
			Irritable bowel syndrome
			Gastroesophageal reflux disease
			Abdominal pain

HISTORY

Prenatal, birth events, and/or injuries such as stress injury, drug exposure, difficult labor, forceps delivery, breech birth, induced labor, Pitocin, anesthesia, anoxia, premature/late delivery, or post –birth problems? Other? Please describe.

_____

_____

Problems with growth and development such as severe or recurrent illness or infections, allergies, emotional difficulties, behavioral problems, appetite/digestion, language/speech, coordination? Walking or talking early? Walking or talking late? Early, late or no crawling? History of ear infections? Please describe.

_____

_____

Please indicate if you have ever experienced any of the following and if yes, please describe:

Physical Trauma YES NO
Date: _____ Describe: _____

Injury YES NO
Date: _____ Describe: _____

Coma YES NO
Date: _____ Describe: _____

Accidents YES NO
Date: _____ Describe: _____

High Fever YES NO
Date: _____ Describe: _____

Serious Illness YES NO
Date: _____ Describe: _____

Surgery YES NO
Date: _____ Describe: _____

CNS Infection YES NO
Date: _____ Describe: _____

Poisoning YES NO
Date: _____ Describe: _____

Anoxia YES NO
Date: _____ Describe: _____

Stroke YES NO
Date: _____ Describe: _____

Heart Attack YES NO
Date: _____ Describe: _____

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Have you (or your child) ever been to the Emergency Room? YES NO
Date: _____ Reason: _____
_____

Psychological stresses/life changes, especially during childhood such as death, divorce, loss, move, school change, job change, illness? Have you (or your child) experienced emotional, physical or sexual abuse or neglect? Please describe.

_____
_____
_____

Currently or recently are you (or your child) on any medications, vitamins, drugs, hormone replacements, allergy or asthma treatments, herbals, supplements, alternative therapies, nasal sprays? Other? Please list name, dosage & indication for use:

Medication Name	Dose	Frequency	Used For
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Surgeries, hospitalization or medical treatments? Was either general or local anesthesia used? Please describe.

_____
_____
_____

Any psychological therapies (psychologist, social worker, family therapist)? Are you currently in psychotherapy? Is so, with whom? Have you ever been given a psychiatric diagnosis? Please describe.

_____
_____
_____

Any educational therapies (tutors, special schools, resource teacher, vision therapy, etc.)? Please describe.

_____
_____
_____

Any neurological or education testing? Do you have copies of these tests or the results? Who administered the testing?

_____
_____
_____

Family History

Have any close relatives experienced problems such as epilepsy, autism, Asperger's alcoholism, mental illness, depression, suicide, incarceration or any of the other problems reviewed in this assessment? Please describe.

_____

_____

_____

Lifestyle Inventory

Recreational drug use? If so, when, what drugs and how did each effect you?

_____

_____

_____

Do you drink alcohol? YES NO

If so, how often? _____ How much? _____

Do you drink caffeine (soda, tea, coffee, energy drinks)? YES NO

If so, how much? _____ What time of the day? _____

Do you use tobacco products? YES NO

If so, what type? _____ How much per day? _____ How long? _____

How many hours per day do you watch TV on Weekdays? _____ Weekends? _____

Do you play computer/video/tablet games? YES NO If so, how many hours a week? _____

Do you spend uninterrupted time on social media (Facebook, Instagram, Twitter, TikTok, SnapChat, etc.)? YES NO

If so, how many hours per day? _____

Do you exercise? YES NO If so, what forms? _____ How often? _____

Do you read for pleasure? YES NO

What do you do to relax? _____

_____ _____

Name of person filling out form Date

_____ _____

Signature Relationship to client