ABF Behavioral Health
Become what you want!

Riverview Office
11131 Winthrop Market St.
Riverview, FL 33578

Westchase Office
10840 Sheldon Rd, Suite B
Tampa, FL 33626

(813) 235-4270 • fax (888) 503-3166
email: info@abfbehavioralhealth.com

NEW CLIENT INFORMATION FORM

Please Fill out Completely (Shaded areas only if applicable)

CLIENT NAME:_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____ **WORK PHONE:**_____

AGE:_____ **DATE OF BIRTH:**_____/_____/_____ **SSN:** _____-_____-_____

____**SINGLE** ____**MARRIED** ____**DIVORCED** ____**WIDOWED** ____**SEPARATED**

RACE: _____ **ETHNICITY:** _____**LANGUAGE:**_____

GENDER: _____**M** _____**F** **EMAIL:**_____

PLEASE PROVIDE THE FOLLOWING:

FATHER'S NAME:_____ **HOME/CELL PHONE:**_____

MOTHER'S NAME:_____ **HOME/CELL PHONE:**_____

FATHER'S EMAIL:_____ **MOTHER'S EMAIL:**_____

GUARDIAN NAME IF PARENTS ARE DIVORCED:_____

EMPLOYED STATUS: ____**FT** _____**PT** ____**SELF** _____**RETIRED** ____**UNEMLPLOYED**

STUDENT STATUS: ____**FT** ____**PT** ____ **N/A**

NAME OF SPOUSE (IF MARRIED):_____

REASON FOR VISIT: (please be specific):_____

FAMILY PHYSICIAN:_____ **PHONE:**_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

REFERRED BY:_____ **PHONE:**_____

CURRENT MEDICATION(S):_____

_____

DRUG ALLERGIES:_____

BRAIN MAPS/NEPSY ☐ YES ☐ NO

HOW DID YOU HEAR ABPOUT US?
☐ INTERNET ☐ RADIO ☐ PRINT ☐ EVENT ☐ FAMILY/FRIEND ☐ BILLBOARD ☐ TV

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PERSON RESPONSIBLE FOR PAYMENT:_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____**WORK PHONE:**_____

AGE:_____ **DATE OF BIRTH:**_____/_____/_____ **SSN:** _____-_____-_____

GENDER: _____**M** _____**F** **RELATION TO CLIENT:** _____

EMPLOYER:_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

OCCUPATION:_____**EMAIL:**_____

AN EMERGENCY CONTACT PERSON IS SOMEONE YOU GIVE ABF BEHAVIORAL HEALTH WELLNESS PERMISSION TO SPEAK WITH IN EVENT OF AN EMERGENCY.

EMERGENCY CONTACT SAME AS RESPONSIBLE PERSON _____**Y** _____**N**

IF NO PLEASE PROVIDE THE FOLLOWING INFORMATION:

EMERGENCY CONTACT:_____

PERSON RESPONSIBLE FOR PAYMENT:_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____ **WORK PHONE:**_____

AGE:_____ **DATE OF BIRTH:**_____/_____/_____ **SSN:** _____-_____-_____

GENDER: _____**M** _____**F** **RELATION TO CLIENT:** _____

EMPLOYER:_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

DO YOU GIVE PERMISSION TO HAVE YOUR PHOTOGRAPH INCLUDED WITH YOUR CHART IN OUR ELECTRONIC MEDICAL RECORD SYSTEM _____**Y** _____**N**

DO YOU GIVE PERMISSION FOR ABF TO LEAVE VOICE MESSAGES ON YOUR HOME PHONE _____**Y** _____**N** **CELL PHONE** _____**Y** _____**N** **WORK PHONE** _____**Y** _____**N**

METHOD OF PAYMENT: ____**CASH** ____**CHECK** ____**CREDIT CARD** ____**OTHER**

SIGNATURE:_____ **DATE:**_____

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HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Social Security Number/Medical Record Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Name

   Address

   City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

   _____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *_____
   NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____

Signature of Individual or Guardian
(The person about whom the information relates)

Date of Individual's Signature

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CANCELLATION POLICY

At ABF Behavioral Health, we understand that unavoidable conflicts or emergencies may arise causing our clients to require rescheduling of appointments. We request that all clients **notify the office at least twenty-four (24) hours prior to your scheduled appointment if unable to attend**. If possible, further advance notice of any conflict would be appreciated.

ABF Behavioral Health cancellation policy is as follows:

Cancellation 24 or more hours prior the scheduled appointment… no charge

First cancellation within 24 hours of scheduled appointment … fee waived

Second cancellation within 24 hours of scheduled appointment … $50.00

Third cancellation within 24 hours of scheduled appointment … $100.00

All appointments scheduled with Dr. Lambos must be confirmed by phone 24 hours prior to the appointment. If the appointment is not confirmed by noon the day of the appointment, your appointment will automatically be cancelled and will need to be rescheduled.

All other appointments cancelled within 24 hours of schedule will be billed at the full treatment rate. Any appointments missed without notice will be billed at the full treatment rate.

_____ _____

Signature of Individual or Guardian Date

We appreciate your business and thank you for allowing us to serve you.

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Interchangeability of Equipment:

I understand that ABF Behavioral Health has acquired new technology, wireless-dry caps, which will be phased into our practice gradually; therefore, the sensor-paste technology will be interchangeable with the wireless-dry technology for our clients. The connection mechanism and visual selection may change from session to session, without impacting the effectiveness of the treatment.

Due to high client volume and last minute changes in the schedule that may occur, clients need to be prepared for either technology to be used during the session. Many of our clients use our hairdryer, bring a hair tie or baseball cap, should they not be going home directly from the session.

Our priority is the effectiveness of treatment and maximizing available session time slots.

We appreciate your support, as we phase in the newest and best equipment available for use today.

Please be aware that hairspray, gels or other hair products may affect the connectivity of this equipment and may require us to reschedule your appointment. You must avoid the use of these products on treatment visit days. There will be no credit issued for appointments discontinued due to this type of connectivity issue.

Interchangeability of Therapists:

I understand that ABF neurotherapists are assigned randomly and selection of a preferred person for the duration of treatment is not available.

Our approach to treatment includes the notion that our clients are better served by being exposed to a variety of neurotherapists, as each team member offers something different in the way of personality and counseling approach. Children with issues of rigidity may have an adjustment period with new therapists, but we believe that learning that they can successfully adjust to new people is necessary positive reinforcement that perpetuates success throughout treatment.

_____ _____

Signature of Individual or Guardian Date

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This document is a consent to receive assessment and/or treatment for behavioral health services from ABF Behavioral Health, a registered D/B/A of American Brain Forensics, LLC., a Florida Corporation.

Because people are individuals, success with any of the modalities is best predicted with a complete evaluation and the development of a treatment plan. The evaluation allows us to predict which symptoms will respond, and which may respond first. And, as with any treatment, there can be no guarantee of success in any particular instance. You are therefore invited to consent to be treated on the basis of this information. Before you give your consent to be treated, we want you to ask as many questions as are necessary for you to understand this process. Please continue to express your questions, observations, and concerns at any time during the treatment process

A Full Assessment and Treatment plan may consist of one or several modalities, including but not limited to:

- Initial Intake Interview
- Psychological, Neuropsychological, and/or Educational Testing
- Quantitative Electroencephalogram as needed (qEEG)
- Z-Score Training
- Direct Current Transcranial Stimulation (tDCS/Eldith)
- Heart Rate Variability (HRV)
- Neurofield (pEMF)

Discontinuing Treatment: You may discontinue treatment at any time for any reason. Should you wish to discontinue treatment, please inform us as soon as possible.

Medical stability: You must be medically stable to engage in training. You must report any changes in medication or any change in other therapies you may be participating in. Reporting any change in supplements or vitamins will also be important. A change in your response to your typical medication regimen should also be discussed with your practitioner. Experience with these treatment modalities may require you to consult your physician about possible medication adjustments that may speed recovery.

Privacy: Your treatment records are private to the fullest extent of the law; that is, except in cases of potential harm to yourself or others, or in civil or criminal proceedings and with a court order.

I have solicited assessment and treatment services from ABF Behavioral Health in good faith, exercising my free will and following the dictates of my own

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conscience which allows me to select what I understand is most beneficial to my health. I am requesting that ABF Behavioral Health provide me with assessment and/or treatment as discussed. I understand that I have the right to refuse any treatment modality at any time.

CONSENT TO TREATMENT:

I, _____, give my full permission to ABF Behavioral Health to conduct an Intake Interview, Assessment, and Treatment Regime consisting of the modalities of assessment and therapy as listed and described above. I understand a permanent data record of the sessions will be recorded and retained. **Initial here**:_____

I acknowledge that I have been given an opportunity to ask questions regarding the assessment and treatment sessions and study, and that these questions have been answered to my satisfaction. **Initial here**:_____

My consent to participate in this treatment is given voluntarily and without coercion. **Initial here**:_____

I have been provided with an explanation of each of the treatment modalities. **Initial here**:_____

By signing below I acknowledge that I have read and understand all parts of this consent and give my consent to receive training sessions as described in my treatment plan.

_____
Print Name

_____ _____
Signature Date

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Major Modalities:

Quantitative Electroencephalographic (QEEG) and Neurofeedback

Areas of applicability: Neurofeedback training has been successfully applied to central nervous system problems, such as symptoms of traumatic brain injury, stroke, fibromyalgia, depression, mood disorders, attentional disorders, hyperactivity, explosiveness, anger, and learning problems. Controlled studies of NEUROFEEDBACK have been completed and other studies are ongoing.

Prior to commencement of Neurofeedback training, clients are assessed via a procedure called QEEG Testing. This involves measuring EEG activity from 19 sites on the scalp, recording the EEG in 1 or 2 (resting/sitting with the eyes closed and/or resting/sitting with the eyes open), and subjecting the data so collected to mathematical analysis based on accepted techniques, and comparison of the results with a normative database.

Effects of NEUROFEEDBACK: NEUROFEEDBACK tends to make functioning clearer and easier. Training has increased cognitive functioning (memory, concentration, attention, ability to learn and to read, organizing, and sequencing), motivation (initiating and completing activities), and motor skills (coordination, balance, grace, decreased spasticity, improved tone and movement). NEUROFEEDBACK appears to work as an antidepressant, elevating the moods of depressed persons. Sleep disorders have been ameliorated with improved sleep at night, and reduced sleepiness during the day. It has increased energy and stamina. Explosiveness, irritability, and background anxiety have been reduced. Pain due to migraines, fibromyalgia and other centrally mediated pain disorders has been reduced. Problems with Restless Legs Syndrome have been alleviated.

Side effects: No significant negative side effects have been observed. The side effects that have been noted will be discussed with you. The side effects sometimes seen with NEUROFEEDBACK are in the form of temporary increases of the symptoms you already have or perhaps symptoms that you have experienced previously. Please report all side effects to your NEUROFEEDBACK practitioner so that he/she can work closely with you to adjust the dosage. This is done the same way your medications are adjusted by your physician. Your willingness to discuss any possible side effects and to understand how they change over time will help you work with us to provide successful Training.

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Transcranial Direct Current Stimulation (tDCS)
Transcranial direct current stimulation is a non-invasive method that shifts membrane potential towards hypo- or hyperpolarization and therefore leads to functional changes in a discrete area of the cerebral cortex. Neurophysiological studies have shown that slow changes in cortical scalp potential reflect overall activity of cortical neuronal networks. These scalp potentials reflect shifts in membrane potentials of the cortical neurons. Over the past 7 years tDCS has evolved as an important tool to non-invasively manipulate specific neural circuits of the human brain.

NeuroField
The NeuroField system is a variable DC stimulation device that is designed to reduce stress and energetically balance the human body. NeuroField is designed to deliver small electrical pulses to the energy field that is generated by the human brain. It is theorized that the energy field created by the brain can absorb energy and deliver it to damaged molecular systems in the body. When the molecular systems are repaired they allow the natural wisdom of the body to engage its regenerative systems so as to promote stress reduction and healing. I understand that the thinking behind NeuroField is theoretical and has yet to be proven using the scientific method.

I understand that all protocols and services associated with the NeuroField are considered exploratory and experimental. I understand that this device does not have FDA approval as a medical device. I understand that there are no research studies showing the effectiveness of NeuroField at this time. At this time ABF Behavioral Health is not aware of any negative consequences from the use of the NeuroField. Should ABF Behavioral Health become aware of any negative treatment effects you will be notified immediately and given options regarding your treatment.

It has been documented that NeuroField can be very stimulating to the point of causing insomnia, but this has been observed in a very small population. NeuroField can cause fatigue and sleepiness. If these side effects occur I understand that I am to inform ABF Behavioral Health so that modifications can be made to my treatment in order to reduce or eliminate these issues.

I understand that the services provided help to correct energetic imbalances. Procedures utilized include stress reduction protocols. I understand that the NeuroField is not a medical device. I understand that the NeuroField does not diagnose or treat medical problems. I understand that the NeuroField services provided by ABF Behavioral Health are solely associated with stress reduction and energetic balancing.