

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: ____/____/____

___ 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 ___ UNEMPLLOYED

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 ABOUT US?

INTERNET RADIO PRINT EVENT FAMILY/FRIEND BILLBOARD TV

PERSON RESPONSIBLE FOR PAYMENT: _____

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

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

AGE: _____ DATE OF BIRTH: _____ / _____ / _____

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: _____ / _____ / _____

GENDER: _____ M _____ F RELATION TO CLIENT: _____

EMPLOYER: _____

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

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: _____

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.

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 Feedback Displays

We offer a variety of visual and auditory feedback displays. During your first five sessions you will be shown a different type of feedback screen. Following the fifth session if you express a preference for a particular type of feedback screen you may elect for that screen during your session. However, you may not change type of feedback screens during the session.

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

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

RELEASE FROM LIABILITY FOR UNATTENDED MINOR CHILDREN

ABF Behavioral Health cannot be responsible for minors left unattended in our offices. I understand that if I (or any other adult I deem responsible) bring a minor child for whom I am responsible to his/her scheduled appointments at ABF Behavioral Health, he/she will be dropped off and picked up within the office. Furthermore, anyone who drops off a minor child for an appointment *must* return prior to the completion of the child's scheduled appointment unless otherwise stated by a staff member of ABF Behavioral Health.

- ***Minor children are not permitted to be left unattended in the waiting area.***
- ***Minor children are not permitted to leave the office unattended.***

Signature of Individual or Guardian

Date

We appreciate your choosing ABF, and we thank you for allowing us to serve you.

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)

If any behavioral assessments are not returned, we are under no obligation to generate an assessment report or return any payments and will terminate the relationship.

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 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

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.

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.