Attention Deficit Disorder Clinic
Robert L. Gurnee, MSW, LCSW, DCSW, BCIA: BCN:QEEG Diplomate, Board Certified Diplomate, Director
8114 E. Cactus Road, Suite 200, Scottsdale, AZ 85260
Telephone: 480-424-7200/Fax: 480-424-7800

TODAY'S DATE:_____

PATIENT'S COMPLETE NAME:_____DOB:_____M/F__

Complete Address:_____

City/State/ZipCode:_____

Home Phone:_____Work:_____Cell:_____

Email:_____Employer/Occupation:_____

_____

PARENT/LEGALGUARDIAN/RESPONSIBLEPARTY/SPOUSE'SNAME:_____

Complete Address:_____

City/State/Zip Code:_____

Home Phone:_____Work:_____Cell:_____

Employer/Occupation:_____Work Phone:_____

Primary Care Physician:_____Phone:_____

Current Medications:_____

In Case of Emergency Contact:_____Phone:_____

Nearest Relative Not Living With You:_____Phone:_____

Whom may we thank for referring you?_____

COMPLETE INSURANCE INFORMATION – ONLY IF YOU WISH FOR A CLAIM TO BE FILED:
Primary Ins:_____Address:_____
Insurance Phone Number:_____Policy Holder Name:_____DOB:_____
ID/Policy#:_____Group/Plan#:_____
Secondary Ins:_____Address:_____
Insurance Phone Number:_____Policy Holder Name:_____DOB:_____
ID/Policy#:_____Group/Plan#:_____

PATIENT CONSENT FORM
(HIPPA COMPLIANCE)

I understand that, under the health Insurance Portability and Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of privacy Practices prior to signing this consent. I understand that this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

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Attention Deficit Disorder Clinic, PLC

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Sessions are 50 minutes long and begin TEN (10) minutes after the time given. The charge for the TOVA TEST is $30.00, IVA TEST is $30.00, ADSA TEST is $30.00, BPI is $30.00 and the Symptom Checklists are $30.00. All other tests are at no charge to the patient.

APPOINTMENTS MUST BE CANCELED FORTY-EIGHT (48) HOURS IN ADVANCE. OTHERWISE, YOU WILL BE CHARGED FOR THE ENTIRE SESSION. MONDAY APPOINTMENTS MUST BE CANCELED BY NOON ON THE PREVIOUS FRIDAY.

_____

(Please initial)

The cost of each session is $130.00 per hour. The responsibility of payment is yours. As a courtesy to you, we will bill your insurance carrier. Payment is due at the end of each session. There will be a finance charge of 1.5% added to your account for any balance left unpaid for thirty (30) days or more, compounded monthly. If your account becomes delinquent and no payments have been made within ninety (90) days, your account may be sent to collections. There is a $75 collection fee and there is a $30.00 charge for all returned checks. I authorize the "A.D.D. Clinic, PLC" to release pertinent information to my insurance carrier and assign benefits directly to this clinic if requested. I authorize the therapist to review the case with other staff members of this clinic and if necessary, mail/fax reports to my personal physician. I have read the above agreement, I understand these policies and agree to abide by them. I, as the responsible party, assume full responsibility for payment of all charges incurred by the patient.

Responsible Party Signature_____ Date_____-

(Parent signature if child is a minor)

Patient Signature_____ Date_____

Attention Deficit Disorder Clinic
Scottsdale Neurofeedback Institute

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Informed Consent For Treatment

Treatment of emotional, behavioral and mental health disorders such as Attention Deficit Hyperactivity Disorder, depression and anxiety involves the active participation of the patient (and their family in most cases). There are many different approaches to treatment including counseling, behavior modification, family therapy, medication, skill training and EEG (biofeedback) neurofeedback. At the Attention Deficit Disorder Clinic we will work with you to plan the treatment program that will best meet your needs.

If you choose to use EEG biofeedback as part of your treatment, you need to be aware that there has been over 30 years of research since this was first developed at UCLA. Although no guarantees or promises can be made that it will be effective, experienced clinicians are usually reporting 80% to 90% improvement rates. Many patients have been found to no longer require medication for their disorder. However, in 10% to 20% of cases people are unable to change their brainwave patterns in desired directions sufficiently to bring about adequate improvements.

Counseling and EEG biofeedback can sometimes bring up painful memories. This can be part of the growth and healing process, however, it can, at times, be emotionally painful. Although side effects from neurofeedback are rare, they can occur. If they do occur they are usually redeemable relatively quickly.

QEEG Topographic Brain Maps are not intended to diagnose neurological disorders. A neurologist will not be reviewing the data for presence of seizures or other neurological disorders. If you suspect a seizure disorder or any other neurological disorder you are strongly encouraged to see a neurologist. EEG biofeedback is usually a helpful adjunctive treatment for many neurological disorders (stroke, closed head injury, seizure disorders, Tourettes syndrome, etc.)

It is uncommon, but if following a treatment session you feel confused, disoriented or light headed, please inform a staff member and rest here until you feel normal again. Do not drive a vehicle until fully recovered.

I have read the above "Informed consent for treatment". I understand that there are usually significant improvements but that some people do not improve, become worse before they become better, or may even, in very rare cases, find their problems have worsened. I hereby release the Attention Deficit Disorder Clinic from any liability related to my treatment and to hold its staff harmless from any effects caused directly or indirectly from counseling or EEG biofeedback.

_____ _____

Patient or Responsible Party Signature Date

For Office use only - verification that client has read and understands informed consent document

Authorized Representative: Date:

Attention Deficit Disorder Clinic and Scottsdale Neurofeedback Institute

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Arizona State Law

I acknowledge that Arizona State Law requires (must) and designates all Behavioral Health Counselors, Case Managers, Clinicians, or Technicians, to report any suspected or reason to suspect cases of **domestic violence, abuse, neglect to include all ages (child or adult)**, to the proper authorities as deemed necessary in behalf of the interested persons to protect their legal rights.

Patient Name:_____DOB:_____

Address:_____

City:_____State:_____Zip:_____Phone:_____

Signature:_____Date:_____

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Price List for Services

$130.00 hour: Psychotherapy, evaluation, testing, family sessions, cognitive and behavioral interventions, reviews of QEEG/Topographic Brain Map results, etc.

Evaluation: 1. One hour or more of history at $130.00 per hour
3. Four or more hours of testing at $130.00 per hour

Tests: Testing is $130.00 per hour and there are licensed tests (four for children) that require extra fees:

TOVA CPT:	$30.00	- all ages
IVA CPT:	$30.00	- all ages
Symptom Checklist:	$30.00	- any age
ADSA:	$30.00	- adolescent and adult
SCL 90 R:	$30.00	- adolescent and adult
ASI	$30.00	- adolescent and adult
Conner's CPT - 3	$30.00	- all ages
CDI	$30.00	- ages 7-17
CPT – 3 (Auditory)	$30.00	- all ages

EEG Neurofeedback:
First session: $130.00

Additional Sessions Purchased PER SESSION:

SINGLE CHANNEL	$ 90.00
MVCT/LCC	$115.00
19 Channel	$140.00

Pre-paid Packages (Cash or checks only): **(If credit card, add 2½%)**

Neurofeedback	SINGLE CHANNEL	MVC/LCC	19CHANNEL
Sessions	@$85.00 = $1,700.00	$110.00	$135.00
Sessions	@$80.00 = $3,200.00	$105.00	$130.00
Sessions	@$75.00 = $4,500.00	$100.00	$125.00

Individual Sessions for LENS: $100.00

- Only this Package of 4500 - Locks in this rate for any future sessions even if there are fee increases.
- No need to buy packages of more than #10 thereafter.

Packages can ONLY be used for neurofeedback sessions. All other appointments must be paid for at time of service.
Unused sessions will be refunded; used sessions will be charged at the appropriate rate above, e.g. #19 sessions @ $90.00 each, #20 at $85.00 each.
Packages purchased can be divided among family members.

QEEG/Topographic Brain Maps:

II. $595.00 – Includes six different Normative Data Bases/QEEG Analysis Systems and Discriminant analyses:

7. New York University QEEG Normative Data Base
8. Thatcher Lifespan Reference Data Base, eyes open
9. Thatcher Lifespan Reference Data Base, eyes closed
10. Neuro-rep QEEG Normative Database and Analysis System – eyes open
11. LORETA Analysis and Normative Database - Eyes closed
12. This does not include a report (if requested) which is $130.
13. If report ordered at time of QEEG with report $650.00 (save $85)

Reports:

II. Conventional Medical EEG report: (Considered additional service) $295.00 to expedite report. Coben Analysis: $305.00

III. Comprehensive Review (1 Hour) of maps, test results, and recommended treatment - $150.00.

Research correlates to available literature of QEEG patterns of psychiatric and learning disorders including the extensive research done at this clinic.

IV. Copies of brain maps, records, and test results - $35.00
V. Evaluation or Treatment Typed Summaries - $150.00

NOTE: ALL CANCELLATION CALLS MUST BE RECEIVED 48 HOURS PRIOR TO THE SCHEDULED SESSION/APPOINTMENT/TESTING/QEEG TIME. THIS WILL AVOID UNECESSARY CHARGES BEING POSTED TO YOUR ACCOUNT. CANCELLATIONS FOR MONDAY'S SCHEDULE MUST BE RECEIVED THE FRIDAY BEFORE THE MONDAY BY NOON.

INSURANCE: We will file insurance claims to your carrier at your request. There is "no guarantee of payment" and most carriers consider our services "alternative" treatment. Payment is requested at the time of service and reimbursements from insurance are requested to be sent directly to the insured.

Payment for all services are the direct responsibility of the guarantor and is required at the time of service unless other arrangements have been made.

I have read, understand, and agree to comply with the terms of this policy.

_____

Print Complete Name

_____

Signature Date