Informed Consent for Psychotherapy, Neurotherapy, and Education from Dr. Kim Calder Stegemann

Certified Clinical Counsellor (#10001301), Board Certified in Neurofeedback (E60320, Ph.D in Educational Psychology

By signing this form, you acknowledge that I have discussed the points below with you and that you have had the opportunity to ask questions. You understand that you or your child will be seeing me for a combination of psychotherapy, neurotherapy, and education. In the case where your child is the identified client, you acknowledge that you have been given the opportunity to discuss and determine what I will share with you from one-to-one sessions with your child.

**Areas of Applicability and Efficacy:** Psychotherapy and counselling have a long history of application for many different psychological issues such as anxiety, depression, PTSD, attachment concerns, and relationship breakdowns. Therapeutic approaches which have a solid research base include CBT (Cognitive Behaviour Therapy), DBT (Dialectical Behaviour Therapy), Solution-Focused Therapy, and Attachment focused therapies. Outcomes include an increased sense of self-efficacy, and personal well-being, enhanced communication skills, and overall improved quality of life.

Neurofeedback is a form of biofeedback which has been successfully applied to central nervous system functioning problems, such as traumatic brain injury, stroke rehabilitation, depression, ADHD, mood and anxiety disorders, and learning problems. Many controlled studies have been conducted and demonstrate the efficacy of neurofeedback for the above problems. Outcomes include increased cognitive functioning (memory, concentration, attention, organization, and sequencing), motivation (initiating and completing activities), and motor skills (coordination, balance, recovery from paralysis), and elevated mood. Some individuals experience improved sleep and reduced sleepiness during the day.

**Potential Risks:** It is important for you to know that both psychotherapy and neurotherapy have potential risks. In psychotherapy, sharing feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviours can be scary, and sometimes disruptive to the relationships you already have. It is important that you consider carefully whether these risks are worth the benefits. Most people who take these risks find that psychotherapy is helpful.

Neurofeedback is a therapeutic approach that is considered to be "minimally invasive" with few side effects. The side effects which sometimes occur are *temporary* increases in the symptoms you already have, or increased or decreased energy. Please let me know as soon as possible about any adverse side effects so that we can adjust your treatment accordingly. If you are on medications, please let your physician know that you are participating in neurofeedback. It may be necessary to slowly titrate down your medications as a result of neurotherapy. Please let me know if there is a change in medication, particularly those medications that could impact your physical/mental stability/stamina.

**Confidentiality:** Confidentiality is of paramount importance in any therapeutic relationship. Confidentiality will be strictly maintained except in the following instances:

* disclosure of child abuse or neglect
* disclosure of plans to harm self or others
* disclosure of abuse or neglect of a disabled or elderly person
* obligation to comply with a court order requiring release of information

I currently store client files inside a filing cabinet in my locked office and on an external hard drive which is password protected. From time to time, I may transport your file from the therapy office to my home office. I will take all measures to safeguard your information.

I will work collaboratively with other professionals who may be involved in your wellness (or that or your child’s). You must provide me your consent to collect and share information with these professionals during the course of the therapeutic process.

I consult with other mental health colleagues on a regular basis to request input for how I might continue to help you on your healing journey. I give some information about your situation to these colleagues but do not use names. These professionals are also bound by confidentiality to not disclose anything they may hear in these consultations.

**Concerns About Treatment:**

You have the right to receive feedback from me concerning how treatment is progressing. You also have the right to get information concerning the rationale for, components of, and empirical evidence supporting various treatments.

My preference is to work collaboratively with you in order to reach your therapy goals. This is best done by reviewing your progress on a regular basis.

Everyone is an individual and therefore, it is impossible to predict or guarantee the success of this treatment for your particular problem/issues. However, it would be unethical to continue treatment, if no impact is observed within 10-20 sessions. You and I will continually monitor your progress and determine how therapy should be adjusted.

If you are dissatisfied with therapy, please tell me so that I can respond to your concerns. I will take such feedback seriously, and treat it with care and respect. If you believe that I have been unwilling to listen and respond to your concerns, or that I have behaved unethically, you can report my behaviour to the Canadian Counselling and Psychotherapy Association (CCPA) and the Biofeedback Certification International Alliance (BCIA).

**Discontinuation of Treatment:** You may discontinue therapy at any time, and for any reason. Please let me know if you wish to discontinue therapy, so that we can plan accordingly. Similarly, if I feel that treatment is no longer of benefit to you, I will inform you of my suggestion to discontinue therapy.

**Payment and Cancellation:** All sessions (individual or bundles) must be prepaid. I require 24 hours’ notice prior to an appointment cancellation. Cancellation less than 24 hours or no-shows will forfeit the prepaid session.

**Unacceptable Behaviour:** If you are violent towards me, threaten me, or harass members of my office or family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

***By signing this form, you agree to participate in psychotherapy and neurotherapy, being informed of side effects, benefits, and risks****.*

*As well, you consent to me collecting and sharing treatment information with the following individuals, for the duration of the therapy:*

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian (if client is under 19 years of age):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_