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

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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), EMDR (Eye Movement Desensitization and Reprocessing), 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.

Neurotherapy is an umbrella term for a variety of approaches that adjust brainwave activity and reduce or resolve brain and body symptoms. The term "neurotherapy" includes Neurofeedback (NFB), neuro-entrainment, and neuro-stimulation. NFB is like biofeedback for the brain using sensors and auditory/visual/tactile feedback, while entrainment uses sounds and lights to train your brain to be in a different state. Neuro-stimulation involves the use of gentle electrical current, infra-redlight, or even pulsed electromagnetic fields to help re-set the brain, particularly if there is under and over activity in or between different parts of the brain.

These different approaches have 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 neurotherapy for the above problems. Outcomes include increased cognitive functioning (memory, concentration, attention, organization, and sequencing), motivation (initiating and completing activities), and improved 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.

Neurotherapy 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 neurotherapy. 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 yourself 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 (end of this form) in order for me to collect and share information with these professionals during the course of our work together.

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 or other identifiers. These professionals are also bound by confidentiality to not disclose anything they may hear in these consultations. I will make notes in your file of the key points of my conversations.

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 of 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.

Email, Phone, and Text Correspondence: Please be aware that general emails are not encrypted. Only formal reports will be sent to you in encrypted fashion, in order to protect your privacy. As well, please be aware that general phone and text correspondence is not encrypted. I will document all of our correspondence through emails, texts, or other digital/on-line formats. Given the unsecure nature of texts and emails, these forms of communication should be used for non-therapeutic matters such as scheduling or cancellations.

On-line sessions are held using a secure, end-to-end encryption platform. If you would like to have an on-line session, please see the attached consent form.

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

Client Signature: _____

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

_____

Date: _____

Consent for Sharing and Collecting Information:

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

Name: _____

Name: _____

Additional Information Sharing:

From time to time I send clients information via email that I feel may be useful for their improved wellness. If you do not wish to receive this correspondence, please indicate here by circling your preference:

I do / do not wish to receive any informational emails. _____Initials