Rose City Therapeutics
8050 SW Warm Springs St, Suite 130
Tualatin, OR, 97062
(971) 224-4089

INFORMED CONSENT FOR NEUROFEEDBACK TRAINING

I hereby authorize Jim Markovics and/or Jen Markovics with Rose City Therapeutics to provide neurofeedback (EEG biofeedback) training for me/my child. I understand that neuofeedback requires the placement of surface electrodes on my (child's) scalp for the purpose of recording EEG and using this signal to provide feedback in the form of video display or games. While there are few risks associated with this procedure, there is a remote possibility of skin irritation from the electrode cream that is used to attach electrodes. The techniques used to attach the electrodes have been used at numerous research institutions for many years and no deleterious side effects have been reported. No alternatives to this procedure exist at the present time. It is a universally used procedure for the recording of the EEG, and a necessary tool for the evaluation of brain function in various contexts. I understand that I can remove the electrodes at any time if I so desire. There is no risk of electric shock from this procedure.

I understand some individuals have reported that neurofeedback training seemed to produce a temporary worsening in some symptoms including feeling more anxious, more distractible, etc. These reactions can be quickly resolved by changing training protocols. I also understand that training may affect my (child's) body's response to medications for my (child's) condition and for unrelated conditions. I understand that I should not stop or alter any of my (child's) medications without consulting my physician. Should new symptoms develop, it is my responsibility to inform my (child's) health care providers including EEG biofeedback providers.

I understand that I (my child) am/is not expected to be harmed in any other way by behavioral or subjective testing or EEG biofeedback procedures and therefore no compensation for injuries will be provided. I understand that if any adverse reaction does occur, I will be informed of counseling and medical services and provided with contact information if so requested.

I further agree that Jim Markovics and/or Jen Markovics may consult with my (child's) primary care practitioner or specialist with regard to the EEG training and the results obtained. I further agree that the data obtained in connection with the EEG training may be used in consultation, studies, and publications, with protection of the privacy and preservation of my (child's) anonymity.

Client Name:_____

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(Date) (Signature of Client or Parent/Guardian)