## LENS Client Demographic Sheet

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| Patient Name: | Social Security #: |
| Street Address: | Date of Birth: |
| City, State, Zip Code: | Home Phone: |
| Gender: | Work Phone: |
| Email Address: | Mobile Phone: |
| Primary Physician: | Psychiatrist: |
| Emergency Contact Person: | Emergency Contact Phone: |
| How did you hear about us? | Marital Status: |

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

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| --- | --- |
| Responsible Party: | Home Phone: |
| Street Address:  | Work Phone: |
| City, State, Zip Code: | Mobile Phone: |
| Relationship to Patient: | Responsible Party SSN: |

**LENS Brief Consent**

**Areas of Applicability:** The LENS has been successfully applied to central nervous system functioning problems, such as symptoms of traumatic brain injury, stroke rehabilitation, fibromyalgia, depression and other mood and anxiety disorders, attention, hyper-activity, explosiveness/anger, and learning problems. Controlled studies on the LENS have been and are being conducted. Several university and medical human subjects review committees have reviewed the LENS treatment and have found it to be “minimally invasive.”

**Effects of The LENS:** The LENS tends to make functioning clearer and easier. It 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, recovery from paralysis). It has elevated mood as an antidepressant. It has improved sleep at night, and reduced sleepiness during the day. It has increased energy and stamina. It has reduced seizures, explosiveness, irritability, spasticity, and background anxiety. It has reduced the symptoms of migraine and fibromyalgia pain, as well as Restless Legs problems.

**Side Effects**: Although no significant negative side effects have been observed so far, the non-significant ones that we have seen will be discussed with you by your LENS Clinician. Your understanding of them will help you work with us to provide successful treatment. The side effects sometimes seen with the LENS are in the form of *temporary* increases of the symptoms you already have. If you experience any side effects, let your LENS Clinician know 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.

**Medical Stability:** You must be medically stable to engage in this treatment. Please tell your Clinician if you have any changes in medication, but especially any changes that could affect your medical stability. At times, your medical stability may be increased by reducing your medication. Your Clinician will ask you to consult your physician in these instances.

**Other Treatments:** Other forms of neurofeedback can have roughly the same effects and side effects as the LENS. No comparative studies have been conducted to permit objective evaluation of which is better, and under what conditions.

**Discontinuing Treatment:** You may discontinue treatment at any time for any reason. Should you wish to discontinue treatment, please inform your Clinician. He or she will cooperate and provide copies of any records for another therapist.

**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.

*Because people are individuals, success with the LENS 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.*

**Consent to Treatment:**

I have been informed of the effects, side effects, benefits, and risks of this treatment, and give my consent to participate in it.

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Name Date

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

Clinician Signature Date

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION:**

I am currently taking the following medications and doses, and have noted what the medications are for and what effects they have on me: (If I am taking no medication, I will write N/A

Medication Dose Instructions Prescribing Physician

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OTC Dose Reason for Taking

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My five most prominent symptoms are:

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**Financial Policy**

Your care and wellbeing is of foremost concern. In an effort to make sure that there is no undue stress in regards to the billing of your account, please familiarize yourself with the following financial policies:

1. All charges regarding your account are your responsibility.
2. Sessions not cancelled 24 hours in advance will result in a session charge
3. If payment for fees is not received, your credit card on file will be charged.
4. There is a $35 fee for returned check or declined cards.
5. If excessive returns on cards or check, you may be asked to pay in cash for all future services.

***Your signature below indicates that you have read the information in this document and agree to abide by these terms.***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Signature Date**

**CREDIT CARD “Signature on File” AUTHORIZATION FORM**

Jamie Schmidt, LPC is hereby authorized to maintain credit card payment information in their secure and confidential files. This form is being provided for you to supply Jamie Schmidt, LPC with this information for an automatic payment option. Your signature authorizes us to review this information and deduct our fees for professional services rendered from the credit card(s) listed below.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* \* \* \* MasterCard, VISA, Discover, & American Express Accepted \* \* \* \* \* \***

Cardholder Name (as imprinted on the credit card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credit Card Number: \_\_ \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_
Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_
Type of Card: \_\_\_\_\_ MasterCard \_\_\_\_\_ VISA \_\_\_\_\_ AMX \_\_\_\_\_DC

By signing this form, I give permission to Jamie Schmidt, LPC to charge my above credit card(s) for fees related to professional services. If I am using my company’s credit card, I am signing as an authorized user. My signature below confirms my knowledge and acceptance of fees, terms, and policies of Jamie Schmidt, LPC. I understand and agree to accept responsibility for payment of any and all professional services rendered should my credit card(s) deny all or part of this charge as it will then become solely my responsibility. I also understand that this authorization will remain in effect unless I cancel this authorization in writing.

Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_