Metrowest NEUROFEEDBACK
Brain training for adults & kids

Informed Consent for Neurofeedback Training

I hereby authorize Judith Lytel, Psy. D. to provide me_____

my child_____ with neurofeedback training.

I understand that this training is used for a variety of conditions which seem to be associated with irregular brain activity, including but not limited to ADHD, depression, traumatic brain injury (TBI), autism spectrum and seizure disorders. Training is recommended on the basis of empirical observation of improvements in others with similar conditions, as well as documented research and case studies.

I understand that EEG biofeedback requires placement of surface electrodes on my scalp for the purpose of recording my EEG, and use of this signal to provide video displays and audio signals.

I understand that, based on reports of some individuals, training may affect my response to any medications for my condition, as well as for unrelated conditions. I understand that I should not stop or alter any of my medications without consulting my physician/psychiatrist. I understand that I should continue ongoing therapies until otherwise advised by my physician. Should new symptoms develop, I understand that it is my responsibility to inform my health care providers, including my neurofeedback practitioner.

I understand that it is my own responsibility to monitor the subjective effects of training and that (along with information gathered in the initial evaluation) neurofeedback is based on detailed reports between sessions, which may be provided via the website. I agree to provide regular updates after each session in order to provide necessary information to the clinician for best results.

_____ _____

Signature of patient/parent Date