Cognitive Organics - Simplified Referral Form

Client Information

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Insurance Card Upload

FRONT OF INSURANCE CARD

BACK OF INSURANCE CARD

Identification

DRIVER'S LICENSE OR STATE ID

Referral Agency (optional)

Agency Name: _____

Referring Contact Name: _____

Phone: _____

Email (if applicable): _____

Cognitive Organics - Simplified Referral Form

Notes or Special Requests:

CONSENT FOR COUNSELING

1/24ss

I hereby authorize **[PractitionerName]** to provide counseling and/or psychotherapy as explained to me. I understand that while this therapy may be beneficial, as with any treatment, there are inherent risks. During counseling, I will discuss personal issues which may bring up uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh this discomfort and can lead to benefits such as improved personal relationships and reduced feelings of emotional distress. I acknowledge, however, that no warranty or guarantee can be made as to the results of therapy.

CONSENT FOR TELEHEALTH COUNSELING

I understand and wish to engage in telehealth counseling.

I understand with telehealth I will not be in the same room as my provider.

I understand that a telehealth consultation or counseling session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

CONSENT TO USE THE TELEHEALTH

By signing this document, I acknowledge:

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, the Telehealth Service provider does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. I do not assume that my provider has access to any or all of the technical information in the Telehealth Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth Service.
4. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.
5. I agree to be in the State where I live for all appointments unless other arrangements have been made with my therapist.

CONFIDENTIALITY: I understand that discussions between myself and my therapist as well as any records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to me. No information will be released without my written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following: abuse of any other person, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose, a negligence suit brought by the client against the therapist, or the filing of a complaint with the licensing or certifying board. If I have any questions regarding confidentiality, I will bring them to the attention of my therapist. By signing this Information and Consent Form, I am giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred me and the insurance carrier responsible for providing my mental health care services and payment for those services. I am also releasing and holding

harmless the undersigned therapist from any departure from my right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my therapist believes that I am in physical or emotional danger or I am a danger to another human being, I understand that my therapist is required by law to contact medical or law enforcement personnel to prevent harm to me or another person, and may contact the person in danger.

Safety and Quality of Care concerns: I will utilize the Incident Report function through the company to address any safety and quality of care concerns that I have or have witnessed. If I feel the incident was not thoroughly addressed I can contact The Joint Commission which is the Accreditation agency for Cognitive Organics. Link

CONSENT TO TREATMENT: Counseling and/or psychotherapy as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent for treatment is thus given as noted by signature. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me, and I understand that I may stop such treatment or services at any time.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits.
- That I have been given ample opportunity to ask questions and any questions have been answered to my satisfaction.

BY SIGNING THE BOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature	Date

Cognitive Organics does not require payment at the time of booking except for consultation appointments.

We do require that you submit a form of payment during sign-up.

By submitting this form, I agree to give Cognitive Organics permission to run my HSA card, credit card, or ACH on file for any amount not reimbursed to Cognitive Organics by the insurance company.

I also acknowledge and authorize Cognitive Organics to use a third-party service for billing, insurance verification, and payment processing. This third-party service may collect, store, and process my payment and insurance information securely on behalf of Cognitive Organics. I understand that this authorization allows them to manage transactions related to my care, including verifying benefits, processing payments, and handling any necessary billing adjustments.

○ Insurance- I am choosing to use my insurance for coverage of services. I understand that I am responsible to supply and update correct insurance information before any appointment. I understand I am responsible for verifying with my insurance company the amount of coverage and in-network status. Any ESTIMATE of service supplied by Cognitive Organics is a courtesy pre-check and not a guarantee of payment. I understand that I am responsible for supplying and updating correct payment information or appointments may be canceled until payment information is brought current. I understand I will be responsible for any amount my insurance does not cover up to the full amount. All invoices are due upon receipt.

○ Self-Pay- I am choosing to pay for service on my own without submitting to insurance. I understand that I am responsible for supplying and updating correct payment information or appointments may be canceled until payment information is brought current. All invoices are due upon receipt.

_____ _____

Client Signature Date

Cognitive Organics LLC

Acknowledgment of 24-hour cancelation policy 1/24 ss

Thank you for being a valued client at Cognitive Organics LLC. We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill all patient's scheduling needs and keeps the agency operating at its most efficient level. Due to the structure of our agency, missed appointments are a significant inconvenience to your clinician, the agency, and other patients. This policy is in place out of respect for our clients AND our clinicians. The standard meeting time for psychotherapy is 53 minutes. Requests to change the 53-minute session need to be discussed with the therapist for time to be scheduled in advance. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot and leave a hole in your therapist's schedule. Please provide our office with as much notice as possible, (more than 24-hour notice) to change or cancel an appointment. You can make changes to your appointments by logging in to your account. You can also notify us if it is less than 24 hours notice by logging in (https://cognitiveorganics.com/) and sending a message in the messaging portal in your account, which notifies your clinician of the cancellation. DO NOT CALL THE OFFICE FOR CANCELATIONS, the phone lines are not monitored 24/7 and voicemail will not be considered notice. Clients who do not attend a scheduled appointment or do not provide more than 24-hour notice to change a scheduled appointment may be responsible for a fee of ***not less than $50 or up to the full amount of the scheduled session***.

INSURANCE: Co-pays and deductibles may be charged up to 24 hours before the appointment to the credit card or account on file. If the charges fail, the appointment may be canceled. If the appointment is canceled with less than 24 hours notice by the client, the amount will not be refunded but will be credited to the account. The credit will be applied toward the late cancelation fee.

SELF-PAY: Self-pay clients may be charged the full self-pay amount 24 hours before the scheduled appointment. If the charges fail, the appointment may be canceled. If the appointment is canceled with less than 24 hours notice by the client, the amount will not be refunded but will be credited to the account. The credit will be applied toward the late cancelation fee.

This fee cannot be billed to insurance and must be paid before the next appointment or that appointment may be canceled. We reserve your appointment time just for you. We do not double-book our clients so that we may provide optimum attention to each person. The more than 24-hour notice allows us to offer that time to a wait-listed client if you can not attend. After two missed or canceled appointments without more than 24-hour notice, you may be switched to a pre-paid self-pay status or your file may be closed, this would require that you make arrangements ahead of time for payment, we would not submit to your insurance and the fee is non-refundable.

NOTE: You will not be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time. Clients can cancel or change appointments online anytime before the 24 hours.

We do require a credit card to be held on file that will be charged for any cancellations or reschedules not done with more than a 24-hour notice. Thank you for providing our office and our clients with this courtesy. I have read, understand, and agree to abide by the policy above:

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made your file may be closed, and the therapeutic relationship discontinued by you. If you decide to resume the relationship you may be asked to complete additional paperwork.

BY SIGNING THE BOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

srs 1/24

SIGNATURES MUST BE YOUR LEGAL NAME

Client Signature	Date

About the LENS

(Low Energy Neurofeedback System)

Information and Administration Consent Form

(Updated 07-26-2021)

Cognitive Organics LLC
300 E Business Way Ste 200-2465
Cincinnati, OH 42541

Phone: 614-610-1396
admin@cognitiveorganics.com

Informed Consent

You are seeking LENS sessions (the *Low Energy Neurofeedback System*, a form of neurofeedback) to address symptom(s) you are experiencing.

Although no significant negative side effects have been observed so far, the non-significant ones that we have seen will be listed later. Your understanding of them will help you work with your LENS Provider to administer LENS sessions. As with any health/healing modality, please be aware that while the overall record of the use of LENS is quite successful, there can be no guarantee of success in your particular instance. You are therefore invited to consent to LENS sessions on the basis of this information. Before signing this document, please read the following and ask as many questions as are necessary for you to fully understand this process.

1. Although the results may sometimes evoke both positive and/or challenging feelings, LENS is not psychotherapy. Some clients may benefit from seeking support and clarity from a psychotherapist.
2. *LENS is not a medical treatment and is no substitute for standard medical care.* If you need standard medical care, you are encouraged to seek it.
3. If you are taking the following medicines, it will be necessary to stay in close contact with your prescribing healthcare provider. It has been observed, thus far, that the need for these medications often decreases with LENS sessions. They remain in your system unused, and people often start experiencing side effects from them because of the decreasing tendency of the body to rely on them. These types of medication include, but are not limited to, the following:

    - medication for blood sugar regulation (diabetes)
    - medication for thyroid problems
    - medication for migraines and/or other types of headaches
    - medication for seizures
    - medication for mood regulation or clarity issues
    - medication for movement disorders and/or spasticity
    - medication for blood pressure regulation

4. Any individual who is not medically stable should request that their LENS Provider consult their normal care / prescribing physician before undertaking LENS sessions.
5. You will be asked to report any unusual, odd, or uncomfortable sensations or experiences to your LENS Provider and to your normal care / prescribing physician.

WHAT IS LENS?

LENS involves measuring and recording electrical signals from the scalp, and uses the frequencies of those signals to guide the speed of a feedback signal from a feedback unit near you. The extremely weak electromagnetic pulses come from the EEG cables and will be neither visible nor will you be able to feel them. The recorded EEG signals influence the electromagnetic feedback. The feedback, in turn, changes the quantity and frequency of the recorded brainwave signals.

In contrast to other brainwave biofeedback procedures, the LENS does not maintain that faster brain waves are better for some problems, or that slower brain waves are better for other problems. Rather, LENS supports the brainwaves: at rest, becoming quieter, and at work, becoming more flexible in their functioning.

The LENS has been used with hundreds of thousands of clients with a wide variety of presenting symptoms.

THE LENS SESSION:
The brainwave recording process may require the use of a mild abrasive gel or witch hazel to clean the skin. After that, electrode gel/cream/paste will be applied to the earlobe clip sensors, and attached to both ears, to improve the quality of the recording. A third and fourth sensor will then be pressed to the forehead or other scalp sites, and held there with a wax paste.

No needles, shocks, skin penetrating, or other invasive procedures are used. The equipment assesses the client's brainwaves – extremely faint electrical signals measured at discrete locations on the scalp. After a short assessment of the nature of these brainwaves, the equipment itself then generates and disburses extremely faint electromagnetic feedback signals that the brain may respond to in beneficial ways.

During the sessions, your eyes will be closed and you will be asked to sit quietly, if possible. Although you will not see anything, your brain can detect the feedback. The speed of the feedback will be controlled by the signals picked up at the scalp.

Your only instructions will be to close your eyes and rest. You will not be asked to think of anything in particular, or to learn anything. You will be asked frequently if you note any changes resulting from the feedback in order to adjust it most effectively. This is a passive process. You will be asked to keep track of any improvements, discomforts, or side effects experienced during and after your LENS session.

In addition, you will be asked (both before administration and 48 hours after every session) to complete a short questionnaire to update your top 10 symptoms.

DURATION:
You will have as many sessions as you need, each session lasting between one second and several minutes in duration. The rest of the time will be spent, as needed, talking about what effects, if any, the feedback has had. These sessions will occur on a regular basis as agreed upon by yourself and your LENS Provider.

It is difficult to predict how many LENS sessions will be required. The following estimates are based on our experience. Some patients have needed fewer sessions, and some have needed more:

1. If your problem came on suddenly after a life of high functioning and you are comfortable with the longer periods of feedback, you can expect 4 – 10 sessions. This is only an average range. However, individuals may require more or less than the average figures.

2 If you have a lifelong history of multiple problems and are very sensitive to the feedback, you may need 20 or so sessions.

3. In a very few circumstances such as stroke, spinal cord injury, very severe head injury, or genetic physiological disturbances, the number of sessions may exceed 40.

RISKS:

LENS and Seizures:
The electromagnetic feedback is not visible to the naked eye – although the feedback signal's influence on the signals measured at the scalp (EEG) is clearly present on the screen of the video monitor.

Seizure activity may be a primary reason to seek LENS sessions. There have been reported seizures in those who have had prior seizures. These seizures may have initially been brought about by allergies and/or inhalant hypersensitivities, asthma, orthostatic hypotension, blood sugar changes, fatigue, overwork, and/or changes in medication.

One of the biggest sources of seizure activity is the hasty and medically uncontrolled decrease in anticonvulsants by the client in attempts to decrease their side effects. We do not recommend such decreases, and urge clients to consult their prescribing healthcare provider about their desires to decrease medications of any kind.

It is important that you realize that LENS sessions alone will not abruptly stop your seizures if you have a history of them. In other words, you will continue to have seizures as you have had them in the past until neurofeedback begins to take effect. Furthermore, the client may experience an increase in the frequency of the CORE 8 events (seizures, tics, migraines, headaches, cluster headaches, stuttering, Tourette, and sometimes explosiveness) after which they begin to decrease in frequency and duration. This can be a cause of concern to those in your life, both personal and professional. You are advised to speak with those in your life about this item and be aware of and comfortable with their potential reactions before you start.

Electromagnetic Field Side Effects:
The long-term effects of using electrical field feedback as we use it is unknown. The intensity of our field is less than one trillionth of a watt and, on average, is on for only a few seconds during each session. A background signal that is approximately a thousand times less than the feedback signal is also present as soon as the EEG begins to read the brainwaves. For reference, a cellular telephone generates a signal at least millions of times greater than the power of the LENS feedback signal.

OTHER POTENTIAL CONCERNS:

Brief Reactions:
There are some potential risks of *temporary* discomfort after receiving LENS sessions. On the rare occasions when the feedback is too intense or the feedback periods are too long, you may temporarily feel wired, tired, irritable, and/or anxious. If this occurs, inform your LENS Provider and the settings on the equipment can and will be changed to make the feedback less intense and shorter in duration, to the extent that you are once more comfortable.

Longer Lasting Reactions:
You may experience one- or two-week periods of anger, fear, and/or irritability. You may feel as if you have tremendous energy to do things, or feel very tired. These longer-lasting reactions have especially tended to occur with particular feelings that people have been struggling to control for a long time. While these feelings can be intrusive and bothersome, it has been the experience of previous clients that they can still function. At times, however, support from a therapist or physician may be useful and should be relied upon.

If you have some degree of spastic paralysis after a stroke or other brain injury, there is a good possibility that you may experience significant pain in paralyzed parts of your body, typically for a period of a week. This pain occurs as the muscles soften around the spastic fibers, and these

fibers no longer have stiff muscle fibers to keep these fibers from spasming. As the muscles continue to soften, the spasms stop, sensation starts to return, and muscle control starts the long process of improving. Those who have problems taking pain medication, perhaps because of adverse side effects, are advised to consider what they need to do to comfort themselves during this painful period. Those who can take medication are advised to do so and consult their physician. If your LENS Provider has access to a photonic stimulator or laser, this type of pain is usually completely avoided. Inquire about these devices.

You must report any and all medications you use while you participate in LENS sessions, and are not to change your medications without consulting your prescribing physician.

When is Something a Side Effect or a Benefit?
While we have had experience since 1990 with the LENS and its antecedents, and are familiar with many of its benefits and side effects, it is sometimes difficult to know when a feeling, benefit, or other problem is due to LENS, or due to something else happening in a person's life. This could be due to anything from an on-coming cold, allergy, a stress in your life, or some other kind of physical change in you, completely unrelated to LENS. In addition, your own background can play a very big part in the kind of experience you have while receiving LENS sessions.
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You do not have to know whether something may be due to LENS, or whether it may be due to something else. If you notice something and wonder about why you are experiencing it, make note of it for later discussion with your Provider.

We recommend that you write notes about your feelings and experiences and make note of any questions that might come up. Bring these notes with you to your sessions to discuss with your Provider.

A Perspective on Side Effects from LENS Sessions:
Although the unexpected is always a possibility, we have always found that any side effects that have occurred in LENS sessions were already familiar ones. In other words, the feelings and medical problems that arose have always been ones that the clients have experienced and are familiar with.

Those whose medical status is unstable are advised to consult with their physician about attaining more medical stability before beginning LENS sessions. For example, the LENS may cause a relaxation effect and for some, a subsequent decrease in blood pressure, which may impact orthostatic hypotension.

It is also important to know that when the problems have occurred during LENS sessions, many have been a fraction of their former intensity, which means that often they have been more manageable than in the past.
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While these problems have only rarely been overwhelming to clients receiving LENS sessions, your comfort is of great importance to your LENS Provider: so, sharing your feelings at any time will help make sure we can best cooperate with your therapist and/or physician.

Between Sessions:
While many people feel energy, ease, clarity, and calmness after a LENS session, these positive feelings may initially wear off between sessions. This "wearing off" of the good feelings may cause clients to become discouraged and doubtful about their ability to reach their goals. The wearing off appears to be the brain's way of struggling to remain in the old, familiar, and dysfunctional state. As people continue with the LENS, the period during which the positive

feelings occur becomes longer and the “wearing off” periods become shorter until they no longer occur.

And for others, some become clearer about their entire range of emotions, rather than staying numb and flat in their emotional responses.

Considerations After Treatment:
It will be time to discontinue the LENS when you stabilize and achieve consistently better functioning. A few people, however, become used to the stimulation that LENS provides, and go into a slump after discontinuing sessions. The session slumps that have occurred have lasted between a few days and a month, and have been less of a problem than those that brought people in for LENS sessions. During this period your body will become accustomed to being open to its own internal useful stimulation. Most of those who have received LENS have continued to improve long after regular LENS sessions have ended.

BENEFITS:
The LENS system has been shown in clinical use to bring about significant improvements in a relatively brief process in physical and emotional rehabilitation. Significantly shorter rehabilitation is of great importance in time, money, and client hopes.

*You may experience an end to the problems affecting you since your head injury and/or psychological trauma, and to the problems that have interfered with your ability to function in your work and personal life.

*The return of clarity, energy during the day, restful sleep, sense of humor, motivation to get things done, ease of getting things done, memory, ability to read and listen with little or no distraction, and the absence of depression, irritability, impatience, and explosiveness have been observed repeatedly.

ALTERNATIVES:
There are other approaches to that of the LENS. Other forms of brainwave biofeedback, also known as EEG biofeedback, are also being used to address the effects of head injuries. However, EEG biofeedback, which has also not been subject to controlled studies, appears to take longer, and appears considerably less effective than the LENS for problems with mood and functioning.

PROBLEMS OR QUESTIONS:
You are encouraged to ask questions at any time.

VOLUNTARY PARTICIPATION:
You are free to withdraw your consent and discontinue participation in LENS sessions at any time.

PROVIDER:
Cognitive Organics LLC supervises this treatment. They can be reached by telephone at 614-610-1396 between the weekday hours of 9 am-4 pm

CONFIDENTIALITY:
Your identity will not be disclosed without your separate consent, except as specifically required by law. Examples of legal requirements for breaking confidentiality are:

* under court order
* in the case of unlawful behavior such as suspected child abuse
* in the case you bring legal action against the Provider or the Provider’s staff

With these exceptions, any data released or published will not identify you by name.

LIMITATIONS OF THIS CONSENT:
This signed form may not be used as consent for any other modality. Participation in any other modality requires a separate form.

All procedures performed under the protocol will be conducted by individuals legally and responsibly entitled to do so.

PERMISSION FOR UNDERGOING LENS SESSIONS:
I, a prospective client, give my full permission to Cognitive Organics LLC supervisor, or other staff of their office to use any data collected during the preparation and participation in LENS sessions. I give up all implied and actual ownership of any data collected. I understand that when data is used, my confidentiality will be protected, and that my identity will not be revealed unless required by law (as outlined previously).

I acknowledge that I have been given an opportunity to ask questions regarding the LENS and that these questions have been answered to my satisfaction.

Initial here: _____

I acknowledge that I have read and understand the above information, and agree to participate in LENS sessions.

Initial here: _____

My consent to participate in LENS sessions is given voluntarily and without coercion.

Initial here: _____

I understand that I may discontinue LENS sessions at any time, and that I may refuse to consent without penalty.

Initial here: _____

Cognitive Orgnanics LLC or other staff of their office has my permission to contact my physician or health care provider to both inform them of the circumstances and outcomes my LENS sessions, and request pertinent medical information about me.

Initial here: _____

I hereby give my consent to Cognitive Organics LLC or the staff of their office, to record all effects of the LENS.

Initial here: _____

I have read and understand the contents of this “Information and Administration Consent Form,” and consent to receive LENS sessions.

Initial here: _____

_____	_____
Signature of Provider	Signature of Client or Parent/Guardian
_____	_____
Date	Date

Client's Printed Full Name: _____ Age: _____

Diagnosis (If Applicable): _____