INSURANCE INFORMATION

Today's Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Patient's SSN: ___-___-____

_____ Home Phone: _____

_____ Ok to leave msg? Yes No

Employer: _____ Cell Phone: _____

Employer Addr: _____ Ok to leave msg? Yes No

_____

INSURED PARTY INFORMATION (If different from above)

Insured's Name: _____ Date of Birth: _____

Insured's Addr: _____ Insured's SSN: ___-___-____

_____ Home Phone: _____

Employer: _____ Ok to leave msg? Yes No

Employer's Addr: _____ Cell Phone: _____

_____ Ok to leave msg? Yes No

Insurance: _____ ID Number: _____

Ins. Comp. Addr: _____ Group Number: _____

_____ Policy Type: PPO HMO Other

Deductible: _____ Co-Pay: _____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance carrier to make payment directly to Behavioral Pain Management, LLC and Ajeet Charate, benefits due me out of indemnity under the terms of my policy or agreement issued by the above named company. Payment is authorized upon the receipt of Ajeet Charate's itemized statement for services rendered to me or the above for the above name patient. I certify that my policy or agreement was in full force and effect at the time that these services were rendered. Payment of the amounts as herein directed, in whole or part, shall be considered the same as if paid directly to me.

Insured's Signature: _____ Today's Date: _____

RELEASE OF INFORMATION

I hereby authorize the release of my information to the insurance carrier necessary to process all claims.

Insured's Signature: _____ Today's Date: _____

I authorize the release of billing information to collections agencies for unpaid balances if necessary.

Insured's Signature: _____ Today's Date: _____

QEEG Code: _____ Therapy Diagnostic Code: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Behavioral Pain Management LLC's, DBA NITI Notice of Privacy Practices. The Notice of Privacy Practices contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA") that may be made by Behavioral Pain Management LLC., and of my rights and Behavioral Pain Management, LLC's legal duties with respect to my protected health information. I have had the opportunity to review the Notice of Privacy Practices and take a copy with me if I so choose.

_____	_____
Patient's Name	Parent/ Guardian Signature (If applicable)
_____	_____
Patient's Signature	Parent/ Guardian's Name (If applicable)
_____	_____
Date	Date

Please sign and return this acknowledgement; it will be maintained in your file.

BPM, LLC

Ajeet Charate, LCPC
Licensed Clinical Professional Counselor

Illinois HIPPA Privacy Notice Form

This notice describes how psychological and medical information about you may be used and disclosed.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your written authorization.

Definitions:
"PHI" refers to information in your health record that could identify you.
"Treatment, Payment and Health Care Operations"
Treatment is the provision, coordination, or management of your health care and other services related to your health care. An example of treatment is my consulting with another health care provider, such as your family physician.
Payment is obtaining reimbursement for your health care. Examples of payment are when your PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations are activities that relate to the performance and operation of the practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, as well as case management and care coordination.
"Use" applies only to activities within the practice such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
"Disclosure" applies to activities outside of the practice such as releasing, transferring, or providing access to information about you to other parties.
"Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information outside of treatment, payment, or health care operations, an authorization will be obtained from you prior to releasing the information.

You may revoke all such authorizations of PHI at any time, provided such revocation is in writing. You may not revoke an authorization to the extent that 1.) I have relied on that authorization, or 2.) If the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures Without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:
Child Abuse-If I have reasonable cause to believe a child known to me in my professional capacity may be an abused or a neglected child, I must report this belief to the appropriate authorities.
Adult and Domestic Abuse-If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.
Health Oversight Activities-I may disclose PHI regarding you to a health oversight agency for oversight activities authorized by law, including licensure and disciplinary actions.
Judicial and Administrative Proceedings-If you are involved in a court proceeding and a

request is made for information by any party about your evaluation, diagnosis, and treatment, and the records thereof, such information is privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated by a third party or when the evaluation is court ordered. You must be informed in advance if this is the case.

Serious Threat to Health or Safety-If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures believed to be necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures considered necessary to protect you from harm.

Worker's Compensation-I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with the laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. Patient's Rights and Psychotherapist's Duties

Patient's rights:

Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations-You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations.

Right to Inspect and Copy-You have the right to inspect or obtain a copy of PHI in my mental health and billing records used to make decisions about you as long as the PHI is maintained in the record. The details of the access process will be discussed at your request.

Right to Amend-You have the right to request an amendment of PHI as long as the PHI is maintained in the record. I may deny your request. The details of the amendment process will be discussed on your request.

Right to an accounting-You generally have the right to receive an accounting of disclosures of PHI. The details of the accounting process will be discussed at your request.

Right to a Paper Copy-You have the right to receive a copy of the notice upon request even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- To maintain the privacy of PHI and to provide a notice of my legal duties and privacy practice with respect to PHI.
- To reserve the right to change my privacy policies and practices described in this notice. Unless you are notified of such changes, it is required that I abide by the terms currently in effect.
- If I revise my policies and procedures, you will be notified in person or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, please contact me at 847-894-8292. You may also contact the Illinois Department of Insurance Consumer Assistance Hotline at (888) 445-5364 or their Consumer Services Section at (312) 814-2427. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions and Changes to Privacy Policy

.

This notice is effective as of the date of your signature. I reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing.

Client Bill of Rights / Informed Consent

BPM LLC, DBA NITI
Ajeet Charate, MA, LCPC, BCN, CADC

BPM, LLC DBA NITI offers QEEG guided Neurofeedback, Biofeedback and QEEG services for conditions associated with irregular brain and nervous system activity. Conditions may include ADD/ADHD, FASD, ASD, LD, impulse control disorder, depression, anxiety, migraines, headaches, CFS, chronic pain, addiction disorders, and more.

Ajeet Charate is certified in Neurofeedback via the Biofeedback Certification Institute of America (BCIA). He has a MA in clinical psychology and is a licensed clinical and professional counselor (LCPC) in the State of Illinois. He is a member of the Association for Applied Psychophysiology and Biofeedback (AAPB), the International Society for Neurofeedback Research (ISNR). He adheres to the ethical principles and guidelines of these organizations.

Biofeedback and Neurofeedback training is a process of providing information to the client about physical, nervous system, and brainwave activity. Sensors are attached to the head and earlobes to gather information. **Nothing is done to the client.** (Both EEG and neurofeedback procedures are non-invasive). The sensors simply measure and report back to the client their own brain wave activity allowing them to adjust as necessary. The information is seen on a computer screen and or heard through speakers or headphones. The client is able to see and hear changes in physiological activity and, by practicing self-regulation techniques such as relaxation and breathing, the client can learn to correct imbalances in the systems being monitored. This process may result in improvement in the client's presenting condition(s), as these functional problems are corrected. The LENS or Low Energy Neurofeedback System, is a unique and very effective form of neurotherapy that facilitates changes in people of all ages who present with a wide variety of issues. Practitioner will discuss further with the client and guardian's about this, if indicated.

Research has been conducted to study the effects of this intervention and these studies have been published in peer reviewed, professional journals relevant to this field of study. Extensive research and clinical experience have demonstrated the effectiveness of neurofeedback interventions for a wide variety of conditions (recent research articles regarding the efficacy of neurofeedback may be provided upon request.) These interventions are considered particularly safe and are generally without harmful side effects. It is imperative that the client attends training at least once per week (better 2 or more /week) and for at least 25 sessions to experience any improvements. Inconsistent or infrequent training and lack of effort can affect the outcome.

Ajeet Charate has six years of clinical experience in neurofeedback and provides these services on the basis of his experience, through ongoing training and review of the research literature. However, beyond this, Ajeet Charate makes no claim or guarantee that neurofeedback/biofeedback training will be effective for your specific concerns.

Clients have the right to discuss any current information about any assessment by this practitioner and the recommended course of training, including how long it is expected to take. Clients can expect courteous and professional treatment by this practitioner. All client records and transactions are confidential unless release of these records is authorized in writing by the client, or otherwise required by law. Clients will have access to their records. Other services may also be effective for a client's condition(s). Information about such services will be provided upon request. Clients have the right to choose freely among available practitioners, and to change practitioners after services have begun. The client can expect a coordinated transfer if they change service providers. Clients may refuse any service or training approach. Clients may freely assert any of these rights.

I have read and understood this document; I have had the opportunity to ask questions and have had those questions answered to my satisfaction. I have received a copy of this document for my records.

Signed: _____ Date: _____

Parent / guardian Signature (if client is a minor): _____ Date: _____

Credit Card Authorization Form

By your signature on this form, you authorize charges to your credit card for services rendered.

I authorize Behavioral Pain Management, LLC to charge my credit card through Clover payment system for any insurance related charges. These will be co-pays, deductible balance etc, once your treatment session has been processed by your insurance. you will also be provided with the billing statement. I also agree that my credit card can be charged $20 for any session that is not cancelled at least 24 hours prior to the scheduled session.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Behavioral Pain Management, LLC in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.

Credit Card Information:

CC number: _____ Exp date: Month: _____ Year _____

3-digit code: _____ Billing zip code: _____

Signature: _____

Date: _____

Receipt to be sent by text: _____

Email: _____

Intake Summary

Name: _____ Male / Female Indic/Couple/Group

Address: _____ Hm Phn: _____ Date Intake: _____

_____ Leave Msg: _____ Reason: _____ Emergency Contact:

_____ Cell Phn: _____ _____

Referred by: _____ Leave Msg: _____ Reason: _____ Phone: _____

Insurance: _____ **Copay:** _____

Email: _____

Text notifications: Cell phone: Yes _____ **No**

Demographic History

Weight: _____ Height: _____

Marital status: _____

Employment status: _____ Job title: _____

Annual income: _____

Preferred language: _____

Smoking: _____ Frequency: _____

Smoking start date: _____ Smoking end date: _____

	Race/Ethnicity	Ed.level	Religion	Date of Birth
	_____	_____	_____	_____
(M)	_____	_____	_____	_____
(F)	_____	_____	_____	_____

Medical History

Medical problems	Date	Length	Current Status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments:

Infectious Diseases?

Current Medications	Amt.	Date	Length	Doctor	Se

Mental Health Treatment	Date	Length	Doctor	Self:

Currently under care of psychiatrists? Yes / No Name: _____ Phn: _____

Address: _____ Diagnosis: _____

_____ Date: _____

Treatment: Release of Info Signed? Yes / No

Counseling / Psychotherapy / other Treatment History

Previous Therapist	Phone	Dates	Length	Type	Reason for Leaving

Diagnosis: _____ Treatment: _____

_____ _____

Release of Info Signed? Yes / No

Previous Therapist	Phone	Dates	Length	Type	Reason for Leaving	Self:

Diagnosis: _____ Treatment: _____

_____ _____

Release of Info Signed? Yes / No

Traumatic Head Injuries

Date	Age	Event	Treatment	Outcome (LOC)

DCFS Involvement

Date Reason for Report Disposition

_____ _____ _____

_____ _____ _____

Counseling required by court? _____ DCFS Contact: _____ Addr: _____

Release of Info Signed? Yes / No _____

Next Court Date _____ Lawyer: _____ Addr: _____

Release of Info Signed? Yes / No _____

Report due date _____ Sent to: _____ Addr: _____

Release of Info Signed? Yes / No Comments:

Legal History

Arrests Date Location Disposition

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_ _____ _____ _____ _____

Counseling required by court? _____ Probation Officer: _____ Addr: _____

Release of Info signed: Yes / No

Verfification required by court? _____ Lawyer: _____ Addr: _____

Release of Info Signed: Yes / No

Bankruptcies:

Probation:

Law Suites:

Education History

Last School Attended: _____ year:_____

Major Subject Area: _____ Deg: _____

Vocational Training: _____ Year: _____

Military History

Military Branch: _____ Service Dates: _____ _____ Rank: _____

Honorable Discharge: _____ Combat: _____ Dates: _____ _____

Law Suites:

Motor Vehicular Accident / Injury

Were you involved in a motor vehicle accident / injury: Yes No

When did this accident / injury happen:

_____

What were the injuries:

_____

Is the case settled or active:

_____

Are you seeking treatment related to this accident / injury:

Work Related Accident / Workers Compensation

Were you involved in a work place accident / injury:

Yes No

When did this accident / injury happen:

_____

What were the injuries:

_____

Is the case settled or active:

_____

Are you seeking treatment related to this accident / injury:

_____

Presenting Problem

Presenting Issues

First Noticed (Started)

Schl: _____ Grade: _____

Tchr: _____ Memory: _____

Current Triggers: _____

Goals: _____

Sleep: Onset: _____ Duration: _____ Interruptions: _____

Quality: _____ Nightmares: _____ Dreams: _____ Sleep Wkg: ___

Headaches:

Seizures:

Genogram:

Birth History:

Sensory Issues:

Suicidal Thoughts / ideation:

Self-injurious behaviors:

History of Trauma:

Hobbies:

Screen Time:

Name: _____ Date: _____

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 ÷ 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Used via courtesy of www.myhealth.va.gov with permission from Charles M. Morin, Ph.D., Université Laval

Have you ever suffered a small or heavy blow to your head? _____
Have you ever lost consciousness following this injury? _____
Have you ever hit your head hard enough to see stars or be dazed for a couple of minutes? _____
Have you ever had a car accident? _____
Have you ever crashed into something / object and if so did your head move back and forth? _____
When playing sports were you ever hit on the head or have you hit your head and / or bumped heads (soccer, hockey, football, baseball, boxing, jumping on a trampoline, sledding, skiing, etc.)? _____

If you answered yes to one or more questions above, please explain:

_____
_____
_____
_____
_____

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – SELF REPORT (WFIRS-S)

Patient Name: _____

Work: _____ **Date:** _____ **Date of Birth:** _____

School: _____ **Full Time** ____ **Part Time** ____ **Other:** ____

_____ **Full Time** ____ **Part Time** ____

Circle the number for the rating that best describes how your emotional or behavioural problems have affected each item in the last month.

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
A	**FAMILY**					
1	Having problems with family					
2	Having problems with spouse/partner					
3	Relying on others to do things for you					
4	Causing fighting in the family					
5	Makes it hard for the family to have fun together					
6	Problems taking care of your family					
7	Problems balancing your needs against those of your family					
8	Problems losing control with family					
B	**WORK**					
1	Problems performing required duties					
2	Problems with getting your work done efficiently					
3	Problems with your supervisor					
4	Problems keeping a job					
5	Getting fired from work					
6	Problems working in a team					
7	Problems with your attendance					
8	Problems with being late					
9	Problems taking on new tasks					
10	Problems working to your potential					
11	Poor performance evaluations					
C	**SCHOOL**					
1	Problems taking notes					
2	Problems completing assignments					
3	Problems getting your work done efficiently					
4	Problems with teachers					
5	Problems with school administrators					
6	Problems meeting minimum requirements to stay in school					
7	Problems with attendance					
8	Problems with being late					
9	Problems with working to your potential					
10	Problems with inconsistent grades					
D	**LIFE SKILLS**					
1	Excessive or inappropriate use of internet, video games or TV					
2	Problems keeping an acceptable appearance					
3	Problems getting ready to leave the house					
4	Problems getting to bed					
5	Problems with nutrition					
6	Problems with sex					

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
7	Problems with sleeping					
8	Getting hurt or injured					
9	Avoiding exercise					
10	Problems keeping regular appointments with doctor/dentist					
11	Problems keeping up with household chores					
12	Problems managing money					
E	**SELF-CONCEPT**					
1	Feeling bad about yourself					
2	Feeling frustrated with yourself					
3	Feeling discouraged					
4	Not feeling happy with your life					
5	Feeling incompetent					
F	**SOCIAL**					
1	Getting into arguments					
2	Trouble cooperating					
3	Trouble getting along with people					
4	Problems having fun with other people					
5	Problems participating in hobbies					
6	Problems making friends					
7	Problems keeping friends					
8	Saying inappropriate things					
9	Complaints from neighbours					
G	**RISK**					
1	Aggressive driving					
2	Doing other things while driving					
3	Road rage					
4	Breaking or damaging things					
5	Doing things that are illegal					
6	Being involved with the police					
7	Smoking cigarettes					
8	Smoking marijuana					
9	Drinking alcohol					
10	Taking "street" drugs					
11	Sex without protection (birth control, condom)					
12	Sexually inappropriate behaviour					
13	Being physically aggressive					
14	Being verbally aggressive					

Number of Items Scored '2' or '3'

A	Family			/
B	Work			/
C	School			/
D	Life Skills			/
E	Self-concept			/
F	Social			/
G	Risky			/
	Total			

Total Score

A	Family		/
B	Work		/
C	School		/
D	Life Skills		/
E	Self-concept		/
F	Social		/
G	Risky		/
	Total		

Mean Score
(N/A items not included in calculation)

A	Family	
B	Work	
C	School	
D	Life Skills	
E	Self-concept	
F	Social	
G	Risky	
	Total	

*Calculated from _____ answered questions.

This scale is copyrighted by Margaret Danielle Weiss, MD PhD. The scale can be used by clinicians and researchers free of charge and can be posted on the Internet or replicated as needed. Please contact Dr. Weiss at margaret.weiss@icloud.com if you wish to post the scale on the Internet, use it in research or plan to create a translation.

BPM, LLC / Neurofeedback & Integrated Therapy Institute

Name: _____ Date of Birth: _____ Gender: Male Female

Date of QEEG: _____ Handedness: Right Left Ambidex

Current Medications	Amount

AXIS I: _____

_____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____ _____ _____

GAF: Current highest Intake

History of Head Injuries?

Year Type of Injury

Any History of Concussions / LOC?

Any Family History of Epilepsy / Seizures?

Any Family History of Bipolar Disorder?

Any Family History of Depressions?

Any Family History of Anxiety Disorder?

Any Family History of Obsessive Compulsive Disorder?

Any Family History of Addictions?

Ever Diagnosed with ADD or ADHD?

Have you ever uses Recreational Drugs?

Observations During EEG recording:

EEG Number: _____

Eyes Closed recording: ___

Eyes Open recording: ___

Therapist: _____ Date: _____

Review Appointment: Date: _____

Location: _____