



**CONFIDENTIALITY**

Client information will be kept in confidence and will not be disclosed to anyone outside of this office without your written consent, unless as is required by law.

**CONSENT**

Your signature below indicates that information above is accurate to the best of your knowledge you have read and understood the information in this document and that you consent to biofeedback training. If you do not understand, it is your responsibility to request and receive clarification before signing.

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Client's Signature	Client's Name	Date
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**FOR PARENTS/GUARDIANS OF MINOR CLIENT:**

I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo biofeedback training.

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Parent/Guardian's Signature	Minor's Name	Date
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