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PATIENT/CLIENT INFORMED CONSENT

This form represents my effort to inform you of important issues you need to consider before entering treatment. The purpose is to make you a knowledgeable consumer, to protect you and me, and to help you make decisions about entering into a relationship with this office. You must agree to these statements to enter into a treatment or assessment or consultative relationship with Dr. Eastridge, but you are free to reject these terms and services from this office.

ISSUES

SERVICES / FEES/ SESSIONS

I have voluntarily chosen to receive services from Dr. Michael Eastridge and/or his associates. I understand that I may terminate treatment at any time. I understand that Dr. Eastridge may also terminate treatment at any time as well, if in his judgement, termination is the most appropriate course to follow.

I understand that therapy is a cooperative effort between me and my therapist. There is no guarantee that I will feel better, but I will cooperate to the best of my ability with my therapist, to accomplish my therapeutic goals.

I understand that sometimes I may talk about issues which are upsetting in nature, but that this is often necessary to help me to accomplish my goals. I understand that I may sometimes leave a session feeling tired or aggravated or certainly "not better", and that this is a normal part of therapy. I understand that Dr. Eastridge may sometimes confront me on certain issues, during the course of therapy, and that I may not like such confrontation. I understand that Dr. Eastridge's intention is to be respectful to me and to provide a service that will ultimately be helpful for me, and will hold him harmless for therapeutic discussions and confrontation. It is my responsibility to discuss any negative feelings with Dr. Eastridge, and if I feel that any comments are unfair or inappropriate, to discuss this in my session, so that this issue may be resolved.

I understand that a session is approximately 45 minutes in duration. (Insurance rates are discounted, based upon a 45 minute "hour"). I understand that this 45 minutes includes all time that I am in the office, involved with secretarial staff, time for billing, note-taking, etc. Usually, the face-to-face time will run longer than 45 minutes, but I understand that this is not a "requirement", and that longer session time is Dr. Eastridge 's prerogative. I understand that sessions usually start within 5 minutes of the scheduled appointment time, but that occasionally, Dr. Eastridge may run a little later, if emergencies arise.

I understand that Dr. Eastridge's fees are: $200.00 for initial consultation,$150.00 per session for psychological therapy, $250.00 per unit for psychological/neuropsychological testing, $350.00 per hour or partial hour for deposition or court testimony plus expenses, and $200.00 per hour for record review. Letters, reports, etc. are billed at $250.00 per hour. I understand that Dr. Eastridge will typically not bill for telephone calls if I am a current patient and I am thinking about harming myself or someone else. If telephone calls (from me, my attorney, or perspective employers, disability carriers, etc.) are not emergency calls, however, I will be billed based upon his hourly rate for therapy or for consultation (in legal matters).

I understand that psychological therapy may require only 1 visit sometimes, and that sometimes many visits are required. I understand that my insurance company may limit the number of visits that will be covered by insurance payments. If my insurance company makes a decision to stop payment for services, while I could still benefit from treatment, I understand that I may continue in treatment at my own expense. If I cannot afford treatment, Dr. Eastridge will, upon request, provide the names of other psychologists in the area, but cannot guarantee anyone's

fee schedule or that free treatment or reduced fees will be available at another office.

I understand that Dr. Eastridge typically does not provide psychological testing under medical insurance, particularly for adults, due to legal and ethical concerns regarding having someone outside of this office controlling how this kind of testing is done. I can receive psychological testing in this office, but it will be at my own expense. I realize that I have the option of pursuing testing at another office, as well. I understand that, in most cases, Dr. Eastridge will test children under medical insurance.

I understand that insurance billing is provided as a *courtesy* by this office, and that it is *not required* by law or ethics that this office bill my insurance. I understand that dealing with insurance companies is time consuming and thus expensive (20 minute simply "on hold" is quite common for a single telephone call). I understand that this office will bill my primary insurance, but that this office may decline to bill multiple insurances for me. I understand that this office will attempt to help me with my primary carrier and with getting bills paid by insurers, but that it is ultimately my responsibility to pay for services rendered, and that this office may, at any time, decline to pursue further efforts with my insurers. I understand that my insurance is *my* benefit, and not the doctor's, and I will take responsibility for ensuring that payment is made for services rendered. I understand that sometimes, months will pass before insurers will resolve billing issues, and that it is my responsibility to "stay on top of" the billing situation.

I may request copies of test results, reports, letters, etc., which are a part of my record. I understand that I will be charged for any copies provided, at whatever rate is in effect at the time of my request. I will be charged for mailing expenses for copies, reports, etc. I understand that session notes for psychotherapy are not typically released to patients/clients or their doctors, because these are the psychologist's subjective notes of session content. If the psychologist feels that session notes will be upsetting to me, or that the session notes are not appropriate to release, he has the option of creating a summary of my session notes. I understand that I will be charged for the preparation of the summary report, at a rate to be determined when I request it.

I understand that Dr. Eastridge does not produce a "report" or "narrative report" for every service provided. I understand that reports and/or narrative reports and/or forms documenting treatment and opinions about various issues (ie, disability, impairment ratings, etc.) will be prepared upon request and that there will be a fee for this service. If I have forms to be filled out, which are not complex, I understand that sometimes this can be done during my session, if I present the forms at the beginning of a session, saving the additional cost of preparing forms/reports at other times. I understand that the decision to handle forms/reports in this manner will be made by Dr. Eastridge, at the time of my request.

Office hours are from 8:30 a.m. until 5:30 pm, Monday through Friday. This office is closed at lunch. Evening hours may be available by appointment. Secretarial support is not available after 5:30 pm on most occasions.

I understand that there may be no other person, other than the doctor, in the office for appointments scheduled after 5:30 p.m. I understand that if I am uncomfortable being in the office with no other persons present, that I may schedule an appointment during regular business hours.

I understand that this office does not provide babysitting services. I understand that if I bring a child/minor to this office, who is not in the treatment session, that it is my responsibility to remain with that child as long as the child is in the office. I understand that during evening appointments, it is my responsibility to see that any child I bring to the waiting room is supervised. I understand that for an older child or adolescent I may leave the office while he/she is in a treatment session, but that I am to return to the office for pick up by the end of the session. If my child/adolescent is instructed by me to walk home from an appointment, I understand that the safety of that child/adolescent is my responsibility.

MISSED APPOINTMENTS

I understand that, unlike a medical physician, a psychologist sees fewer patients over the course of a day, and that my appointment is a reservation of the psychologist's time during which he/she earns a living. When I miss an appointment without giving notice, I prevent the psychologist from earning an income for that time. I understand that I may cancel my appointment with 24 hours notice, and I will not be billed for that appointment. I understand that I will be billed for a missed appointment if I do not cancel at least 24 hours before the appointment time. I understand that my insurance will not pay for missed appointments and that the burden of full payment will be mine. I understand that if I cancel with less than 24 hours notice, and the psychologist can schedule another appointment in my time, that I will not be billed for that missed appointment (There will be no "double-billing" for missed appointments. If we can schedule someone else, you are off the hook). I understand that this is the office policy,

and that I may refuse to participate in treatment at this office if I feel this policy is unfair.

CONFIDENTIALITY

I understand that I have the right to confidentiality, and information collected about me will be held in confidence according to federal and state laws governing confidentiality, privacy of health information, and release of records and information.

I understand that Federal and State law requires all health professionals to report any suspicion of child abuse, abuse of the elderly , or abuse of mentally incompetent persons to the proper authorities. I understand that this does not allow for Dr. Eastridge to utilize his judgement, or to investigate prior to any reporting, but that *any suspicion of abuse* must be reported, and this requirement to report supersedes any right to confidentiality. This law was passed for the purpose of protecting persons who may not be able to protect themselves.

I understand that all persons in this office will do whatever they feel is appropriate to protect me from harm. This may include informing others if I am suicidal or homicidal, or if I am at risk to harm myself. This may included involuntary commitment to a psychiatric facility, if that is the least restrictive way to protect me that is available to Dr. Eastridge. (Involuntary commitment happens about once per 5 years in this practice, so be assured that we will endeavor to find the least restrictive means to protect you, that we can).

I understand that there are certain circumstances in which the law may require a release of my confidential records. I understand that if I am involved in a criminal trial, when I am accused of a serious crime, the court may demand my records. I understand that if I am involved in a personal injury lawsuit in which I claim psychological injury, that my records may be obtained by subpeona. I understand that if I am involved in litigation for child custody, that my records may be obtained by subpeona. I understand that there may be other instances in which my confidential records may be subpeonaed. I understand that Dr. Eastridge will attempt to inform me whenever there is a request or subpeona for my confidential information, and that I may, at my own expense, attempt to stop any release of records from this office. (Bottom line: Sometimes your records may be obtained via legal means. I will try to inform you in time for you to stop this, if you wish, but I will not go to jail or incur expense to myself to stop such efforts to obtain your records).

I understand that, if I am seeing Dr. Eastridge under Worker's Compensation benefits, that there is no confidentiality of records with regard to the insurer, my employer, case managers, nurses involved in my case, etc. Dr. Eastridge will protect my confidentiality from sources outside of the Worker's Compensation parties, utilizing the same procedures as for other clients/patients of this office. I understand, however, that Florida law requires Dr. Eastridge to allow parties involved in my Worker's Compensation claim to have access to my confidential records.

I understand that when I use insurance to pay for services in this office, that insurers may request sufficient information to process claims for payment. This usually involves submission of a standard form to my insurance companies, but some managed care programs may require more detailed information. Dr. Eastridge will release information as required by my insurer. I understand that my insurer is required to keep this information confidential, but that Dr. Eastridge cannot guarantee how that information will be handled by my insurance company. (Most insurance companies have confidentiality policies that you may request directly from them). I also understand that Dr. Eastridge will release the information necessary to collect fees for services rendered in this office, should it be necessary to utilize an outside agency to collect unpaid fees.

I understand that I may request that Dr. Eastridge communicate with other health care professionals by signing the appropriate release forms in this office. I may also refuse to release information to other health care providers.

I understand that if I request other parties to call Dr. Eastridge for information, that Dr. Eastridge will typically not release information without my signed consent. (In some emergencies, Dr. Eastridge may make the judgement that the most appropriate course would be to release information to protect you).

CONTACT OUTSIDE OF THE SESSION

Dr. Eastridge may be called at this office during business hours, Monday through Friday. If you are in a life or death crisis, or at a doctor's office, you may ask to interrupt Dr. Eastridge's session, for a moment. You may make arrangements in advance to call Dr. Eastridge after hours at home or on his cell phone. If you indicate that you are at risk to harm yourself or others, please also request Dr. Eastridge's cell telephone number and home telephone number. In case of emergency and you do not have the home telephone number, Dr. Eastridge is listed in the

Tampa directory, and his number may be obtained from directory information services. If you do not receive a return call, either Dr. Eastridge did not get a message, or the office got side-tracked. It is our intention to return your call. If you do not receive a return call in a timely manner, please call back. For non-emergency, non-business issues, Dr. Eastridge's e-mail address is listed on his business card.

I understand that Dr. Eastridge may be contacted at home or by cell phone in an emergency. I understand that I must make arrangements in advance to get these telephone numbers. I understand that after hours telephone contact is reserved for emergencies (life and death) only. I understand that Dr. Eastridge may sometimes be involved in activities (coaching kids, washing the car) in which a telephone may not be available. I understand that I must leave a message with my name, telephone number and the nature of the emergency in those instances. In situations in which I cannot wait for a call-back, I understand that I should call 9-1-1 for emergency help.

I understand that email is reserved for nonemergency communication. I understand that I may not schedule or cancel appointments, or generally speaking, discuss therapy via email. I understand that Dr. Eastridge may not check email on a daily basis and that he may not be able to guarantee confidentiality of email/electronic communications. I understand that I should put my full name in the "subject" line on any email communication. I understand that emails may be placed in my record. I understand that Dr. Eastridge would love to hear how I am doing periodically, particularly after therapy is completed. I understand that if I bring up ongoing therapy issues or crises via email, that there is not much Dr. Eastridge can do immediately. I understand that by bringing up such issues, I am giving Dr. Eastridge permission to respond via email and will take responsibility to ensure that these communications are as confidential and protected as I require, at the email address I used to contact Dr. Eastridge.

PSYCHOLOGICAL SERVICES WHICH REQUIRE PHYSICAL CONTACT

Psychological services are usually limited to services which can be provided via dialogue, but sometimes certain modalities of treatment require physical contact between the psychologist and the patient. In this office, biofeedback and psychological testing require physical contact.

Biofeedback is usually provided in this office for pain management and / or various anxiety or stress disorders. Biofeedback involves using a computer with various types of measurement devices to measure a patient's physiological functioning, and then to present "feedback" to the patient, which is used to teach a patient to change his/her physiological functioning. For example, a person with headaches may have EMG electrodes taped to the surface of the skin on the forehead or neck, in order to measure muscle tension in those areas. The computer might then play a musical tone or show a picture which gives the patient feedback about how tense the muscles are. The patient then tries to change the tone by changing muscle tension the areas being tested, thus reducing muscle tension and alleviating the headache. Modalities most often used in this office require instruments to be attached either to the : face, forehead, neck, shoulders, back, fingers, or sometimes around the chest (for breathing exercises). Typically, for electrodes, the surface of the skin should be exposed to be swabbed with alcohol, then the electrodes will be taped to the skin. Patients will be instructed to dress in clothing that will allow access to the area of the body involved. The psychologist will prepare the area and attach and then remove electrodes as appropriate. There is no need to undress. Sometimes access to the back may require moving the shirt back (for the upper back and shoulders) or moving a shirt up or waist of pants down a bit for access to the lower back. Patients will usually be informed regarding this process a session prior to actually beginning biofeedback. Biofeedback usually takes place in a small room ("lab") and the patient usually sits in a reclining chair during the procedure.

I understand that physical contact is required for utilization of biofeedback procedures. I understand that it is my responsibility to wear clothing that I am comfortable with for the procedures which will be explained to me. I understand that I do not have to participate in biofeedback if I am uncomfortable with the procedures. I understanding that by participating in biofeedback, I am agreeing that physical contact will occur. I understand that touching of clothing and / or the area of my body in question is a part of this procedure. I understand that it is my responsibility to say that I am not comfortable with a procedure, and that every effort will be made to address my comfort level if I participate in this procedure. I understand that I may refuse biofeedback as a treatment modality.

Psychological / neuropsychological assessment (testing and evaluation are other terms for this service) may involve touching, usually of the hands and arms. Usually the purpose of touch is to measure the sense of touch, or perception of skin sensation. Sometimes a patient may be asked to wear a blindfold to prevent "peeking" during such a test.

I understand that some psychological assessment procedures involve physical contact, and consent to that contact when it is part of the evaluation process. I understand that I may refuse to participate in an assessment process which involves touching, blindfolding, etc. I understand that complete evaluation, at times, may require physical contact, and that if I refuse to consent to those procedures, no one will be upset, but the evaluation may be considered to be incomplete.

If I am the parent of a minor who is being assessed or is using biofeedback, I understand and agree that my child may be touched in these situations. I understand that I may request to be present when physical contact is utilized as a part of treatment and or assessment.

One related issue arises when a patient either has suffered physical scars/marks due to injury or self-inflicted wounds (ie, "cutting"), or there is suspicion of an eating disorder. The psychologist may request that a patient expose his/her arms by lifting sleeves or removing a jacket, etc, to inspect for scars (particularly in cases of self-injury), or to raise the pants, shorts, or skirt to the upper thigh to inspect for scars. A person who is being evaluated or treated for injuries which leave scars (ie, dog bite wounds) may be asked to show a scar or picture of scar, if the scar does not involve the genitals. This may be necessary if the psychologist is being consulted (in a lawsuit, for example) about the lasting effects of an injury which left a scar.

I understand that the psychologist may request to see actual scars. I have the right to refuse to do so. I have the right to be present if my minor child is asked to show his/her arms or legs or scars or pictures of scars. I understand that the purpose of this is to obtain objective evidence of injury.

CONFLICTS OF INTEREST

Conflicts of interest occur when the patient's/client's interests are compromised by competing interests of others. This office will try to avoid conflicts of interest, to the extent that it is reasonable to do so. If a patient/client feels that there is a conflict of interest, it is the responsibility of the patient/client to tell Dr. Eastridge, so that this issue may be addressed.

Whenever couples are seen together for therapy for their relationship, it is the usual practice of this office to refer one or both to other psychologists for individual therapy, if needed. In rare instances both members of a couple may be seen for individual therapy by the same provider, if both members of the couple agree to this. Sometimes, in family therapy, there are many competing interests. Patients/clients involved in family therapy acknowledge that conflicts may arise, and that dealing with these conflicts is a valid and valuable aspect of therapy.

Sometimes it is acknowledged that an insurer, employer, attorney, court, etc., may have interests in treatment or assessment of a patient/client that may be different than those of the patient/client, and these potential conflicts should be addressed by either Dr. Eastridge of the patient as concerns arise.

Whenever children become involved in therapy, no matter which family member came to this office first, the best interests of the child supercede the interest of other parties. Dr. Eastridge will determine the best interests of the child from a psychological perspective. Parents, however, have ultimate decision-making power, and when the parents' and psychologist's opinions regarding the best interests of the child differ, the parents may choose to terminate treatment with this psychologist. (The psychologist does not have the option of providing services which he feels are not in the best interests of the child).

Sometimes a relationship may exist between the psychologist and a patient/client may exist outside of the professional doctor-client relationship, and both parties will make an effort to avoid conflicts of interest. Relationships include social acquaintance and business relationships.

For example, the ethics code for psychologists makes bartering for services somewhat difficult (ie, trading so many sessions of therapy for dental cleaning, when the client is a dentist), so it is the general practice of this office to avoid bartering for services.

It is the general practice of this office to avoid buying services and/or products from patients/clients. Exceptions may occur when the patient/client owns or works for a company with which the psychologist may do business, or when the patient/client provides a service or product and there is no reasonable alternative for the psychologist to purchase that service or product from another business/individual.

The purpose of these policies is to protect the patient / client from undue pressure or influence due to some other relationship between the doctor and patient outside of the office. In practice, this is sometimes difficult to detect, much less to prevent. The goal is thus for any conflict to be addressed to the satisfaction of the psychologist and the patient. It is the patient's responsibility to point out perceived conflicts of interest even if the psychologist does not, with the understanding that either party may be unaware of such conflicts at a given moment.

I understand that I have a right to address conflicts of interest and resolve them to my satisfaction. I understand that it is my responsibility to address any conflicts of which I am aware, and that if I feel that a conflict of interest cannot be resolved to my satisfaction, that I may seek psychological services elsewhere.

CHILDREN

Parents must sign appropriate consent forms for children to participate in therapy. In some cases, older teens may be provided treatment without parental consent if that treatment is considered by the psychologist to be in the best interest of the child.

I understand that parents have a right to know what is going on in therapy, and that as a parent, I am expected to ask questions as they arise. I understand that parents will be asked to spend some time with the psychologist in order to discuss the treatment and assessment of minor patients. I understand that sometimes, at the end of a session, there may not be time to start a consultation between parent and psychologist, but that I may schedule an entire visit for such a consultation, or request time at the beginning of a session. I understand that Dr. Eastridge will welcome my participation in my child's treatment.

I understand that the parent who enters a minor into treatment with this office will be responsible for paying for services for the minor in question. I understand that noncustodial parents may have questions about treatment/assessments, and that, in many cases, it is reasonable for the noncustodial parent request information about such services. I understand that in cases of severe disagreement between parents about whether a minor can participate in therapy, that it will be my responsibility to gain consent for treatment from the other parent. I understand that Dr. Eastridge has the option of not treating a minor, if parental conflict could lead to either additional distress of the minor, or legal hassles for the doctor.

Ultimately, minors have a right to confidentiality as do adults, with the exception that parents can obtain information regarding their minor child. I understand that Dr. Eastridge asks that I respect my minor's right to confidentiality, but that I have the right to know what the treatment goals are and how those goals are being addressed.

I understand that Dr. Eastridge will provide therapy for children and families going through divorce and/or custody issues. I understand that Florida law requires a psychologist to be either a "treating" psychologist (who treats the family) or an "expert" witness (who does not know the family prior to evaluating them for custody determination). Dr. Eastridge does not perform custody evaluations. Dr. Eastridge will provide reports to the court, in custody cases, only with regard to factual issues regarding treatement of the family, but will not provide an *opinion* regarding which parent should have custody of a minor. Dr. Eastridge will not see either the children, parents , or family for treatment and then prepare any kind of report to be used in court without agreeing prior to treatment that a report may be requested. I understand that Dr. Eastridge will charge a separate fee for any reports prepared for use in court, in accordance with the fee schedule noted above.

CONSULTATIVE EVALUATIONS

I understand that when I am evaluated by a psychologist, for a service referred to as a Consultative Evaluation (Independent Medical Exam, Independent Consultative Exam, Independent Psychological Exam, etc.), that I am not Dr. Eastridge's patient. I understand that this type of exam is performed at the request of a third party (disability insurer, etc.) for use in determining benefits, litigation, or for some government or corporate or judicial decision-making process. Dr. Eastridge is responsible to the referring entity for these exams, making the referring entity the acutal "client" of Dr. Eastridge. I understand that records and reports of such exams will be provided to the party requesting the exam, and that Dr. Eastridge will not provide such information directly to me. (It can usually be

obtained from the party paying for the exam, however).

I understand that my relationship with Dr. Eastridge is not the typical "Doctor-Patient" relationship when my only relationship with Dr. Eastridge is for purposes of a consultative exam. I understand that it is my responsibility to provide Dr. Eastridge with information which is relevant to the exam, and to be certain that all important information is provided during the course of the exam. I understand that consultative exams may include tests which measure my reliability and the validity of my complaints and responses to test items. I understand that sometimes I will not be informed when these tests are utilized and that sometimes I may not be able to identify when tests of validity are being used. I understand that I should be honest and open and at the same time that I will be treated with respect while in this office.

I understand and agree to the terms involving consultative exams.

OPEN COMMUNICATION

I understand that the purpose of this document is to inform me about issues which may arise when I participate in psychological services, so that I may make an informed decision about entering into a relationship with Dr. Eastridge and/or other providers in this office. I understand that this relationship is important and that it may have significant impact upon my life. I understand that I have a responsibility to discuss issues which may arise in the course of treatment/assessment. I understand that open communication is necessary in order for me to have the best experience possible in this office.

I understand and agree to the terms/procedures discussed above.

Signature_____

Date _____

Larger Print Version Available upon request.