STRIVE
Towards better mental health

Registration Information

***Instructions*: Please complete all items. Indicate N/A if not applicable.**

Patient Name: _____ Preferred Name: _____
Last *First* *MI*

Mailing Address: _____
Street *City* *State* *Zip*

Cell Phone #: _____ Home Phone #: _____ Other #: _____
Can we leave you a voicemail? ☐ Yes ☐ No If yes, which line(s)? _____

DOB: _____ Social Security #: _____ - _____ - _____ Sex: ☐ Male ☐ Female ☐ Other: _____

Email Address: _____ Would you like text/email reminders? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact: _____ Phone #: _____
Name *Relationship*

Guardian/POA (if applicable): _____ Phone #: _____

Primary Care Provider: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Employer: _____ Phone #: _____

How did you hear about our office? _____

Insurance Information

Primary Insurance: _____ Effective Date: _____

Insured's Name: _____ Group #: _____ ID #: _____

Insured's DOB: _____ Relationship to Patient: _____

Secondary Insurance: _____ Effective Date: _____

Insured's Name: _____ Group #: _____ ID #: _____

Insured's DOB: _____ Relationship to Patient: _____

Medical Release Information

Can we discuss your medical condition or test results with your family member(s)? ☐ Yes ☐ No

If yes, who can we share your information with? _____

Can we fax a copy of your result(s) to another physician if need be? ☐ Yes ☐ No

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Consent for Treatment & Office Policies

1. Consent for Treatment
I voluntarily consent to receive psychiatric and/or therapeutic services. I understand that services may include evaluation, medication management, psychotherapy, and other behavioral health interventions. Treatment is **a cooperative process**, and I may **refuse or discontinue treatment at any time**, except as limited by law.

2. Nature & Risks
Treatment may involve discussing difficult topics and emotional discomfort. Benefits may include improved functioning and insight. There is **no guarantee of results**.

3. Confidentiality & Limits
All records are confidential under **federal and state law**, including HIPAA. Limits include:

- Risk of harm to self or others
- Suspected abuse/neglect of a child, elderly, or vulnerable adult
- Court orders
- Necessary coordination with insurance or healthcare providers

4. AI-Assisted Documentation
Strive uses an **AI scribe** to assist with documentation.

- **Does not record or store audio**
- **No patient names or DOBs entered**; only age and gender
- Drafts are **reviewed and finalized by the provider**
- **Does not replace clinical judgment**

5. Coordination & Communication
Information may be shared with insurance, pharmacies, or healthcare providers as needed. Strive is **not a crisis service**; call **911 or go to the nearest ER in an emergency**.

6. Financial Responsibility & Office Policies
I understand and agree to the following office policies:

- **Appointment Cancellations / No-Shows**: Patients are required to provide **at least 24 hours' notice** if they are unable to keep a scheduled appointment. Failure to provide timely notice may result in a **late cancellation or no-show fee**, which must be paid prior to rescheduling.
- **Prescription Refills**: Requests for prescription refills require **72 hours' notice** and may only be made **during normal business hours.**
- **Insurance Information**: It is the **patient's responsibility to keep insurance information current**. If updated information is not provided, the patient may be responsible for self-pay fees for services rendered.
- **Financial Responsibility**: Patient is responsible for co-pays, deductibles, and any self-pay charges. A **current fee schedule is available upon request.**

7. Patient Rights & Privacy Notice
Strive Mental Health LLC posts the Florida Patient Bills of Rights and our HIPAA Notice of Privacy Practices in the office and online at: www.strivementalhealthllc.com
Patients are encouraged to review these documents. Full copies are available upon request.

Acknowledgment – Signature Required
I have read, understand, and consent to the above policies. I understand my rights and responsibilities as a patient.

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

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Controlled Substance Agreement

The Florida Legislature regulates the prescription of controlled substances. These include narcotics, benzodiazepines, sleep aids, and ADHD medications (e.g., codeine, oxycodone, Valium, Xanax, Concerta, Vyvanse).

To comply with these laws and for my safety, I agree to the following:

1. **Prescription Limits**: Prescriptions are generally limited to a **30-day supply**.
2. **Single Prescriber & Pharmacy**: Only my Strive provider will prescribe controlled substances. I **will not obtain these medications from other providers**. Prescriptions and refills will be sent electronically to the pharmacy I designate below.
   - Pharmacy Name & City: _____
   - Pharmacy Phone #: _____
3. **Refills & Notice**: I must request refills **at least 72 hours in advance** during normal business hours. **Refills will not be provided at night or on weekends**.
4. **Appointments**: I must be seen by my provider every **30–90 days** to continue receiving refills.
5. **Lost / Misplaced Medications**: The clinic is **not responsible** for medications that are lost, stolen, or misplaced. Early refills will not be provided.
6. **Testing / Monitoring**: Routine lab work and **random urine drug screens** may be part of my treatment plan and must be completed when requested.
7. **Compliance & Consequences**: Failure to follow this agreement may result in **discontinuation of controlled substances and/or discharge from care**.
8. **Legal Obligations**: It is a crime to obtain controlled substances under false pretenses, including:
   - Using multiple providers or pharmacies
   - Misrepresenting information to obtain medications
   - Selling or diverting medications
   - If there is reason to believe I have violated this agreement, the provider may **notify law enforcement** and cooperate fully. Confidentiality is waived to the extent required by law.
9. **Provider Discretion**: Medications may be discontinued and care terminated for:
   - Misuse, trading, selling, or sharing medications
   - Violation of this agreement
   - Missing required labs or appointments
   - Laboratory evidence of undisclosed or illegal substances
   - Aggressive behavior toward staff
10. **Acknowledgment of Responsibility**: I understand it is my responsibility to **keep my insurance information** updated and may be responsible for self-pay charges if I fail to do so.

I have read, understand, and agree to follow the policies above. I acknowledge that failure to comply may result in **loss of controlled substance prescribing and/or discharge from the practice**.

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

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