STRIVE
Towards better mental health

Informed Consent

Please read and sign acknowledging that you have read and understand the informed consent.

I have chosen to receive psychiatric/therapeutic services from Strive Mental Health LLC. My choice has been voluntary, and I understand that I may terminate treatment at any time.

I understand that there is no assurance that I will feel better because medication management and therapy is a cooperative effort between me and the provider. I will work with my provider in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that all records are confidential and will be held and/or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my provider report all cases of abuse or neglect of minors or the elderly.

I understand that state and local laws require that my provider report all cases in which there exists a danger to myself and/or others. I understand that there may be other circumstances in which the law requires my provider to disclose confidential information.

I understand that my provider may disclose any and all records pertaining to my treatment to insurance companies, insurance representatives, pharmacy representatives, primary care physicians, or pediatricians if such disclosure is necessary for claims processing, case management, coordination of treatment, and/or utilization review purposes.

I understand that I can revoke this consent at any time, except to the extent that treatment has already been rendered or that action was taken in reliance on this consent. If I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefits plan.

I have read and understand the basic rights of individuals (outlined below) who undergo treatment.

These rights include:

1. The right to be informed of the various steps involved in receiving services.
2. The right to confidentiality under federal and state laws in relation to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make informed decisions whether to accept or refuse treatment.
5. The right to contact and consult with counsel and select practitioners of my choice and at my own expense.

_____ _____

Signature *Date*

_____

Relationship (self, parent, guardian, or conservator)

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

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

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

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

STRIVE
Towards better mental health

Patient Contract

Please read and sign below acknowledging that you have read, understand, and agree to the patient contract.

Appointments: If a patient is unable to keep their scheduled appointment, we require 24-hour notice. In the event they do not give a 24-hour notice, they will be billed a late cancellation or no-show fee. All fees must be paid before future appointments can be scheduled.

Emergency Contact Numbers: We are an out-patient practice and none of our staff have admitting privileges at local hospitals. If anyone is experiencing a life-threatening emergency such as violent or suicidal thoughts, they must call 911 immediately.

Prescription Refills: Prescription refill requests require 72-hour notice and can only be made during normal business hours. A follow-up appointment may be required prior to the refill being prescribed.

Insurance & Patient Responsibility: It is the patient's responsibility to notify us of any insurance changes. Our office will submit claims to the insurance company we have on file. Per our contractual agreement with insurance companies, we must collect all co-payments, coinsurance amounts and/or deductible amounts due from the patient. Co-payment, co-insurance and/or deductibles are due at the time of service. Should the insurance company not cover the service, the balance will become payable by the patient. Any balance due from the patient that is not paid within 120 days will be referred to a collection agency and services may be terminated. **You agree to reimburse us any collection agency fees, which may be based on a percentage at a maximum of 21% of the debt, along with all costs and expenses, including reasonable attorneys' fees, we incur un such a collection effort.**

Release of Records: All patients or their parent/legal guardian must sign a consent authorizing the release of any information. No information will be released without a properly executed consent form. Record requests may take up to 30 days to process and pre-payment is required.

Fees Not Covered by Insurance: Fees for the items listed below are not covered by insurance companies and are the patient's responsibility. Fees for these items must be paid at the time the service is rendered and prior to the next scheduled appointment.

- Fees for medical records sent to attorneys or other agencies
- Fees for no shows or cancellations less than 24 hours before the appointment
- Fees for returned checks
- Fees for disability forms, FMLA forms, or letter preparation

Reasons for Discharge: The reasons outlined below are common reasons for discharge from our office. This list is not comprehensive, and the treating provider has final authority on the termination of treatment.

- Continuously cancelling or not showing for scheduled appointments
- Not following the recommended treatment plan (including but not limited to filling multiple prescriptions, supplementing prescribed controlled substances, or not completing required lab work)

Confidentiality: In accordance with moral, ethical, and legal guidelines regarding a patient's right to confidentiality, the patient's personal information is carefully guarded. However, there are some exceptions listed below which must be noted.

- If a patient poses a threat to his or her own safety or the safety of others, we are required to notify concerned parties and the authorities.
- If a patient reports actual or suspected abuse of any individual, our office must notify the proper authorities.
- In patient groups of two or more, including the lobby, check-out, and the Spravato treatment room, confidentiality is urged but not guaranteed.

Authorization & Signature on File: By signing this form, I authorize Strive Mental Health LLC to release all necessary information to insurance companies to process claims or obtain authorization for treatment. I authorize payments be made to Strive Mental Health LLC from insurance companies, government agencies, or any other agency providing benefits for services rendered. I authorize that a copy of the signature below may substitute as the original.

_____ _____

Signature *Date*

_____

Relationship (self, parent, guardian, or conservator)

STRIVE
Towards better mental health

Controlled Substance Agreement

Between Patient: _____ and Strive Mental Health

The Florida Legislature has laws governing the prescription of controlled drugs. These drugs include all narcotics (such as codeine, hydrocodone, and oxycodone), sleepings aids, benzodiazepines (such as Valium, Xanax, and Ativan), and ADHD medications (such as Concerta, Metadate, Ritalin, and Vyvanse). To comply with these laws, I acknowledge and agree to the following:

1. Prescriptions for most controlled substance medications can only be written for a 30-day supply.
2. I agree that only my provider will prescribe controlled substance medications. I will not obtain or use any controlled substances from a source other than my provider. I will instruct my other providers to confer with my provider for any changes or need for additional controlled substance medications. If it is discovered that other providers are prescribing medications for me, my provider reserves the right to discontinue prescribing medications and/or discharge me from the clinic.
3. Prescriptions and refills for controlled substance medications must be electronically sent to the pharmacy. All medications should be filled at the same pharmacy, when possible. The pharmacy I have selected is:

   _____ _____
   Pharmacy Name & City *Pharmacy Phone #*
4. My provider's office requires a 72-hour notice to refill prescriptions. Prescriptions can only be refilled during normal business hours. They will NOT be refilled at night or on weekends. I must provide proof of identity to pick up my prescription for controlled substance medications.
5. I must be seen by my provider every 30-90 days to continue to get refills.
6. My provider's office is not responsible for any controlled substance medications that have been misplaced, lost, or stolen. **Controlled substances cannot be refilled before the renewal date.**
7. Routine blood work and random urine drug screens may be part of my treatment plan. I agree to have them done on the day my provider requests it.
8. If I do not follow these policies, my provider will not be able to continue to prescribe these medications for me.
9. It is a crime to obtain narcotics under false pretenses. This could include getting medications from more than one provider, misrepresenting myself to obtain medications, using them in a manner other than prescribed, or diverting the medications in any other way (selling). If my provider has reason to believe that I have violated this agreement, the provider has the right to notify and cooperate with law enforcement. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my records.
10. My provider has the right to discontinue controlled substance medications and discharge me from care if any of the following occur:
    - I trade, sell, misuse, or share medication with others
    - The clinic discovers I have broken any part of this agreement
    - I do not go for blood work or urine tests when asked
    - My blood or urine shows the presence of medications that my provider is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
    - I get controlled substance from sources other than Strive Mental Health LLC providers
    - I exhibit any aggressive behavior toward the physician or staff
    - I consistently miss appointments

I hold Strive Mental Health LLC harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the above policy.

_____ _____
Patient/Guardian Signature *Provider Signature*

_____ _____
Printed Patient's Name *Printed Provider's Name*

_____
Date

STRIVE
Towards better mental health

Fee Schedule

The fees outlined below are effective March 18, 2024. This is not a comprehensive list of all fees in this office. Please inquire about current fees prior to authorizing any service that is not covered by your insurance company.

- $150 Initial Appointment for Self-Pay (As of January 1, 2025, this amount will increase to $180)
- $85 Follow-Up Appointment for Self-Pay (As of January 1, 2025, this amount will increase to $100)
- $40 Returned Check Fee
- $100 No Show Fee (or for cancelling with less than 24 hours notice)
- $250 Letter/Form Preparation Fee (i.e. Disability, FMLA, etc)

I have read, understand, and agree to the above fees.

_____ _____

Signature *Date*

_____

Relationship (self, parent, guardian, or conservator)

STRIVE
Towards better mental health

Authorization for Release of Information

I hereby authorize **Strive Mental Health LLC** to:
☐ RELEASE (and or) ☐ RECEIVE

Check all that apply:
☐Treatment Goals & Progress
☐Evaluations & Assessments
☐Substance Use/Abuse Assessment & Treatment (including labs & medication)
☐Medical/Psychiatric Assessment & Treatment (including labs & medication)
☐Other (specify) _____

In compliance with FS 90.503, 394.459(9), 394.4615, 395.3025(2)(3), 397.507(7), & Federal Regulations 45 CFR, Part 164.508(c)(1) & 42 CFR Part 2

Information from the records of:

Client Name: _____

Address: _____

_____

DOB: _____ SSN#: _____

Phone: _____

To/From (circle one):

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

For the purpose of:
☐ To Assist in Evaluation & Treatment
☐ Other (specify) _____

A signed revocation may be submitted at any time but Strive Mental Health LLC shall not be held liable for any information released prior to its receipt. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law. Your signature on this authorization is not required to receive treatment.

This release form shall be valid for (check one):
☐ A single disclosure
☐ A continuing disclosure for 90 days from signature date below
☐ A continuing disclosure for 1 year from the signature date below

To Receiving Agency: Prohibition of re-disclosure: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

I acknowledge that I have read, or have had read to me, this authorization and fully understand its contents. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

_____ _____
Signature *Date*

_____ _____
Printed Name *Relationship (self, parent, guardian, or conservator)*

PLEASE RETURN INFORMATION TO: 2440 N ESSEX AVE, CITRUS HILLS, FL 34442 PHONE:352-558-8054 FAX: 352-218-8485

STRIVE
Towards better mental health

HIPAA NOTICE OF PRIVACY PRACTICES

Strive Mental Health uses an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy and insurance company through a secure electronic prescription connection which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability and coordinate your care between us and your specialists, this will allow us to access your medication history through the pharmacies and insurance companies' electronic database.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" (PHI) is information about you, including demographic information, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information (PHI): Your PHI may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

a. Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Also, your PHI may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

b. Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

c. Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers' compensation, and inmates. Required uses and disclosures: under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights: Following is a statement of your rights with respect to your PHI.

a. You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

b. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

c. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

d. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

e. You have the right to obtain a paper copy of this notice from us, upon request, if you have agreed to accept this notice alternatively (i.e. electronically).

f. You may have the right to have your provider amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

g. You have the right to receive an accounting of certain disclosures we have made, if any, or your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone on our main number.

STRIVE
Towards better mental health

Florida Patient's Bill of Rights and Responsibilities

Florida Statutes Chapter 381 (026) Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for the purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.