integrative PSYCHIATRY
Valerie Balandra, ARNP
David Scheiderer, MD
3392 Magic Oak Lane
Sarasota, FL 34232 941-371-7997

Registration Form

Patient Name: _____ Date: ____/_____/_____

Address:_____City_____State_____Zip_____

Phone-Home #: _____Cell #_____ Date of Birth:_____ Age:_____

Preferred Pharmacy Name & Phone #_____

Parent/Legal Guardian (if applicable)_____

Consent for Mental Health Services

I_____ am requesting to receive treatment from Integrative Psychiatry Inc. I have been informed of the nature and purpose of this service, and that my consent can be revoked at any time. No guarantee or assurance has been made to me as to the results that may be obtained from these services. This a release of any and all liability to Integrative Psychiatry Inc. and its practitioners and staff from any decisions or actions I may or may not take as a result of the treatment I receive at this center.

Signature_____Date _____

Patient's Rights & Complaint Process

I understand that I have a right to refuse treatment at any time. I have a right to review my records. I understand that if I feel that my rights have been violated, it is my right to file a complaint with the State of Florida. For further information please visit: http//ahca.myflorida.com/hipaa/

No Show and Cancellation Policy

The fee for a No Show visit or cancellation of less than 24 hour notice will result in a $100.00 charge. Please respect the time of Dr.Scheiderer, his staff and other patients.

This fee must be paid before any further services are provided.

I certify that I have read and understand all of the above information and I accept all terms and fees therein and have received information on patient rights including the process for initiation, review and resolution of complaints. I also acknowledge that I have received a copy of our Notice to Privacy Practices.

_____ _____ _____/_____/_____

Print Patient Name | Patient Signature | Date

_____ _____ _____/_____/_____

Printed Guardian Name | Signature of Guardian | Date

Contact Information

What phone number should we call?_____ cell or home (circle one) . If unable to reach me: Please check your preference.

- Leave me a detailed message
- Leave a message asking me to return your call

Release of Clinical Information: I understand that my clinical information will not be released without my (the patient) written consent to any parties however I do understand that it may be released if required by law for the follow reasons:

- If there is imminent danger of self-neglect or self-harm or imminent danger to another individual.
- If there is suspicion of child, elder or the disabled abuse or neglect.
- If legal action is brought involving mental health damages.
- If there is a court order signed by a judge.
- If evaluation or treatment is provided with forensic involvement.
- If emergency treatment is needed

Prescription Policy:

- You must inform your prescribing provider of any and all medications currently being prescribed by all other providers
- Please call ahead and allow at least 3 business days from when you notify the office for refills to be processed. CALL AHEAD-DO NOT WAIT UNTIL YOU HAVE 1 PILL LEFT.
- If you are receiving any type of controlled medications such as benzodiazepines or stimulants. Please note: they will not be refilled early regardless of the reason. Please take your medications as prescribed and keep your medications in a safe spot to avoid this situation

.**Letters and Record Requests:**

- Please allow 14 days for any records or letter requests
- There is a $25.00 fee for any letters requested.

After Hours Coverage:

- When the business is closed I understand, in the event of an emergency I must call 911 or go to the nearest emergency room.
- I understand that the provider is NOT on call after hours of business.

Financial Agreement:

I understand that payment is full by cash or credit card is expected at the time of visit. Personal checks are not accepted.

I understand I will be provided with a super bill to submit to my insurance for your office visit if requested.

I understand and agree to abide by all of the information provided on this document.

_____ _____ _____/_____/_____

Print Patient Name Signature of Patient/Guardian Date

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New Patient Paperwork

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email: _____

Place of Birth:_____ (city and state; provide country if outside U.S.)

Occupation: _____ Height: ___′ ____″ Weight: _____ Sex: _____

How did you hear about our practice? _____

Social Security Number _____ Medical Insurance Co.: _____

Group # _____ Contract # _____

Today's Date _____

1. Please check appropriate box(es):

☐ African-American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Reason for visit: _____

_____

IFM
THE INSTITUTE FOR FUNCTIONAL MEDICINE

3. Please list current problems in order of priority, and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Postnasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

4. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   _____
   _____
   _____

5. Do you have any pets or farm animals? ☐ Yes ☐ No
   If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Both indoors and outdoors

6. Have you lived or traveled outside of the United States? ☐ Yes ☐ No
   If so, when and where? _____
   _____

7. Have you or your family recently experienced any major life changes? ☐ Yes ☐ No
   If yes, please comment: _____
   _____

8. Have you experienced any major losses in life? ☐ Yes ☐ No
   If so, please comment: _____
   _____

9. How important is religion (or spirituality) for you and your family's life?
   ☐ Not at all important
   ☐ Somewhat important
   ☐ Extremely important

10. How much time have you lost from work or school due to illness in the past year?
    ☐ 0–2 days
    ☐ 3–14 days
    ☐ More than 15 days

11. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, Convulsions, or Seizures		
k. Gallstones		
l. Gout		
m. Heart Attack/Angina		
n. Heart Failure		
o. Hepatitis		
p. High Blood Fats (cholesterol, triglycerides)		
q. High Blood Pressure (hypertension)		
r. Irritable Bowel		
s. Kidney Stones		
t. Mononucleosis		
u. Pneumonia		
v. Rheumatic Fever		
w. Sinusitis		
x. Sleep Apnea		
y. Stroke		
z. Thyroid Disease		
aa. Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
a. Back Injury		
b. Broken Bone (describe)		
c. Head Injury		
d. Neck Injury		
e. Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
a. Pap Smear		
b. Vaginal/Pelvic Ultrasound		
c. Mammogram		

d. Breast Ultrasound		
e. Breast MRI		
f. Breast Biopsy		
g. Cholesterol Check		
h. DEXA Bone Density		
i. Chest X-ray		
j. Colonoscopy		
k. Upper endoscopy		
l. Spine X-ray		
m. Neck X-ray		
n. NMR/MRI		
o. Skin Check		
p. EKG		
q. Abdominal Ultrasound		
OPERATIONS	**WHEN**	**COMMENTS**
a. Appendectomy		
b. Dental Surgery		
c. Gallbladder		
d. Hernia		
e. Hysterectomy (cervix/ovaries removed?)		
f. Tonsillectomy		
g. Other (describe)		
h. Other (describe)		

12. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

13. How often have you have taken antibiotics?

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		
Teen		
Adult		

14. How often have you have taken oral steroids (e.g., cortisone, prednisone, etc.)?

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		

Teen		
Adult		

15. What medications are you taking now? Include nonprescription drugs (excluding supplements).

MEDICATION NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list: _____
_____

16. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate dosage in mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

VITAMIN/MINERAL/ SUPPLEMENT NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		

integrative
PSYCHIATRY

Dr. David Scheiderer, MD Valerie Balandra, ARNP

HIPPA Release of Information

Note: Your emergency contact must be listed on this form.

I, _____
hereby grant Integrative Psychiatry permission to speak with and/or release any information pertaining to my condition(s) to

Primary Contact

Additional Person(s) _____

_____

By signing this agreement, I understand that I am granting the above person(s) direct access to the contents of my medical files. This agreement is effective immediately and will remain in effect until further notice is given. This agreement may be voided at any time with my written notification.

Patient Signature ____/____/____ Date (M/D/Y)

Witness Signature ____/____/____ Date (M/D/Y)

Do you give us permission to leave messages on your answering machine?
(Please initial next to one)

Yes _____ *No*_____

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Fax: (941)-371-7667
www.integrativepsychiatry.net