GONINO CENTER
for Healing

Directions

Thank you for choosing Gonino Center for Healing for your healthcare needs. We are looking forward to partnering with you along your wellness journey. Please see below for directions.

Address 6720 Horizon Rd
Heath, Texas 75032

From Dallas/Garland traveling east on I-30
Go past Lake Ray Hubbard
Exit 67A (Village Dr/Horizon Dr)
Keep left on service road
Turn right at the light onto Horizon Rd
Continue on Horizon until you go past HWY 549
We are the 3rd lot past Hwy 549 on the right

From Greenville traveling west on I-30
Exit 68 (Route 205)
Turn left under I-30
Go 1.5 miles to Hwy 549
Turn right onto Hwy 549
Go 2 miles to Hwy 3097/Horizon Rd and turn left
We are the 3rd lot past Hwy 549 on the right

If you are having difficulty due to road construction or traffic, please feel free to contact our office at 469-402-2800 and one of our staff members will be more than happy to assist you with alternate route assistance.

"Love Heals"

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Gonino Center for Healing Philosophy

Integrative medicine is an approach to care that puts the patient at the center and addresses the full range of physical, emotional, mental, social, spiritual and environmental influences that affect a person's health. Employing a personalized strategy that considers the patient's unique conditions, needs and circumstances, it uses the most appropriate interventions from an array of scientific disciplines to heal illness and disease and help people regain and maintain optimum health. It is a partnership between patient and practitioner in the healing process.

At Gonino Center for Healing, we believe that injured and damaged tissues in the human body are healed by nutrients not drugs and that when symptoms arise in the body the reason is secondary to one or more correctable imbalances and/or deficiencies. The body has a self-healing capacity and at its optimum level, its power supersedes conventional medicine.

As a physician, my passion is to educate and empower my patients with truth and inspiration.

I look forward to having a front row seat to your miracles!

Love Heals,

V. John Gonino, D.O.

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Welcome

Welcome to Gonino Center for Healing. We are pleased you have chosen us to be your partner in healthcare and are confident that you have made the right decision. Gonino Center for Healing providers focus on 'The Whole Person'. As we innovate and grow, we keep one thing at the forefront of all we do, and that is what is best for our patient - what is best for you.

The trust and confidence you have placed in us is most appreciated. The precious gift of health is an investment. In order to help you get the most out of this worthwhile investment and be seen as efficiently as possible, we suggest you arrive in our office 15 minutes prior to your scheduled appointment with your packet of New Patient paperwork completed in advance.

Your New Patient visit will consist of the following (please allow 2 to 3 hours):

Microscopy Appointment
- Scheduled directly before your appointment with Dr. Gonino.
- This allows for education surrounding red blood cell health and oxygen carrying ability, fungus, candida, heavy metals, liver stress, parasites and bacteria.
- It will help Dr. Gonino customize your unique wellness program.
- Tour of the Wellness Center

Provider Appointment
- Dr. Gonino is looking forward to meeting you.
- Establishing a unique plan for you to support health, resolve acute problems and treat chronic illness.
- Labs (if needed)

New Patient Liaison
- Will review/discuss the following…
  - your IV Therapy Wellness Program (customized just for you)
  - Supplements
  - Breathing & Wellness Classes
  - Yoga and Tai Chi (complimentary)
- First IV Therapy (if applicable)

It is a great pleasure to welcome you to the Wellness Center. We encourage you to empower your body to heal.

Sincerely,

The Gonino Center for Healing Team

V. John Gonino, D.O.
6720 Horizon Rd ● Heath, Texas 75032 ● PH 469.402.2800 ● FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Intravenous (IV) Therapies

Intravenous therapies are advantageous because they bypass the digestive system resulting in maximal efficacy and healing. Based on your symptoms, existing diagnoses and/or what is witnessed on your live blood analysis Dr. Gonino will recommended one or more intravenous therapies as part of your overall wellness program.

DETOXIFICATION
Caspofungin
Diflucan
DMPS Chelation
DTPA Chelation
EDTA Chelation
Hydrogen Peroxide

RESTORATIVE
Amino Acid
Glutathione
Phosphatidylcholine
Ozone
Saline

NUTRITIVE
Albumin
Alpha Lipoic Acid
Mineral Boost
Multivitamin
Vitamin C

RECOVERY
Levaquin
Rocephin
Salicinium
Superoxide Dismutase
Zithromax

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Patient Questionnaire

Patient Name _____ DOB ____/____/ _____

If you are seeing other specialist doctors, please complete below with all contact information (full name of doctor, phone number and city). Dr. Gonino in turn may consult with your other healthcare providers regarding your patient care. For this reason, please fill out and sign the records release form attached for each provider listed below. You may make copies, or we can provide additional copies if needed.

Main reason for visit _____

1) List names and address of other Physicians/Specialists you are seeing for care:

   Name _____ Phone # _____
   Specialty _____ Treatment you receive _____
   _____

   Name _____ Phone # _____
   Specialty _____ Treatment you receive _____
   _____

   Name _____ Phone # _____
   Specialty _____ Treatment you receive _____
   _____

2) Are you taking medication that you wish to get off of? If so, please indicate the name of the medications(s) _____

   What are you taking them for? _____

   What reaction(s), if any, have you experience with this medication?
   _____
   _____

3) What do you hope to get with the treatment Dr. Gonino has to offer? _____
   _____
   _____

4) What natural remedies are you currently using? _____
   _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Patient Questionnaire *(continued)*

Patient Name _____ DOB ____/____/ _____

Are you receiving treatment such as Acupuncture, Chiropractic, Ozone Therapy, Infrared Therapies, Colonics, etc. by another physician/practitioner? ☐ Yes ☐ No
If yes, please describe _____

Cancer Patient Questionnaire

1) Have you ever had chemotherapy or radiation? ☐ Yes ☐ No
If no, why?_____

2) Are you currently under the care of an Oncologist?
If yes, list physician's name: _____
Address: _____ City/State: _____ Zip: _____

3) Are you currently receiving chemotherapy or radiation? ☐ Yes ☐ No
If yes, please describe your treatment(s): _____
_____

4) Do you intend to pursue or continue chemotherapy or radiation therapy? ☐ Yes ☐ No
If no, why? _____
_____
_____

By signing below, I authorize and request the disclosure of all protected information for the purpose of review and evaluation with my other healthcare providers.

_____ ____/ ____/ ____
Patient Signature Date

_____ ____/ ____/ ____
Provider Signature Date

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Medical Records

Authorization to Release Medical Records

This form authorizes the release of a copy, summary or narrative of any medical record (as indicated by the check mark(s) below), or to otherwise disclose confidential information.

_____ Complete Medical Record

_____ Records of care from the following dated _____ to _____

_____ Records of care concerning the following condition(s): _____

Release information TO:

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

Initial _____Date _____

Name/Facility	V. John Gonino, D.O., P.A.	DBA Gonino Center for Healing
Address	6720 Horizon Road Heath, Texas 75032	
Phone	(469) 402-2800	Fax (469) 402-0348

Release information FROM:
Name/Facility _____

Address _____ City _____ State ____ Zip _____

Phone _____ Fax _____

The reasons or purposes for this release of information are:

_____ Continuity of Care _____ Transfer of Care _____ Physician Referral

_____ Personal Use _____ Other _____

Signature of Patient or Representative _____

If signed by someone other than the patient, please state relationship _____

_____	_____	_____
Printed Name of Patient	DOB	Date

Patient Registration Form

Gonino Center for Healing
V. John Gonino, D.O.

Today's Date _____

Last Name _____ First Name _____ M.I. _____

Address _____ Apt/Unit # _____

City _____ State _____ Zip _____

Cell Phone # _____ Day Phone # _____ Evening # _____

Email Address _____ Preferred contact method _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Driver's License # _____ Marital Status ☐ Single ☐ Married ☐ Other

Your employer _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone # _____

Referred by _____

Insurance Information – Please Provide Insurance Cards at Check In

Primary Insurance Plan _____ Policy Holder Name _____

Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder DOB _____ Social Security # _____ Contact # _____

Address if different from patient _____

Employer Address _____

Policy ID # _____ Policy Group # _____

Copay Amount _____ Deductible Amount _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Patient Registration Form *(continued)*

Secondary Insurance Plan _____ Policy Holder Name _____

Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder DOB _____ Social Security # _____ Contact # _____

Address if different from patient _____

Employer Address _____

Policy ID # _____ Policy Group # _____

Copay Amount _____ Deductible Amount _____

Appointment Policy Notification

I, _____, am aware of the policy that went into effect February 24, 2009 starting that I will be charged if I miss my appointment.

I understand that I must cancel and/or reschedule an appointment by giving 24 hours advance notice.

I understand that I will be charged $200.00 for missing a new patient appointment and $70.00 for missing an existing patient appointment.

I understand that if I am more than 10 minutes late, I could possibly be considered to have missed my appointment.

I understand that Gonino Center for Healing will make every attempt to make courtesy reminder calls, however it is ultimately my responsibility for making it to my appointment and/or appropriately cancelling.

_____ _____

Signature of Patient or Representative Date

Relationship to Patient _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Patient Consent

Patient Consent Form

Definitions: "I", "me," and "my" mean the patient. I understand I am signing this agreement to obtain services.

Assignment of Benefits

I hereby assign and transfer to the physicians providing services and/or the insurance benefits covering services for the payment of services rendered. I understand it is my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance co-payments and deductibles.

_____ _____

Signature of Patient or Representative Date

Authorization for Care

I grant permission for Gonino Center for Healing to render such care that my physician may deem necessary in my diagnosis and treatment that may include medical treatment and minor surgical procedures.

_____ _____

Signature of Patient or Representative Date

I understand that I may receive care and I consent to care that is provided by a Nurse Practitioner (NP) or Physician Assistant (PA) whom are license professionals working under the supervision of a physician and that they may discuss my care with my doctor.

_____ _____

Signature of Patient or Representative Date

Authorization for Release and/or Acquisition of Information

I hereby authorize Gonino Center for Healing to release and/or acquire necessary protected health information from third parties, including but not limited to other physicians for continuing professional care, any insurance company or third-party payer for the purpose of processing a claim, or otherwise as allowed by law. I release Gonino Center for Healing from any liability for the release and/or acquisition of this information, and I understand this release specifically includes any and all blood related tests, including those for HIV and other diseases.

_____ _____

Signature of Patient or Representative Date

Relationship to Patient _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Medical History

Patient Medical History Form

Medical History

1) Do you have pain? ☐ Yes ☐ No If yes, where and how long? _____
2) Do you see a chiropractor for pain? ☐ Yes ☐ No If yes, where and how long? _____
   _____
3) What treatments are you doing for pain? _____
4) Do you have medical problems that a doctor has followed you for in the office on a regular basis? Ex: high blood pressure, diabetes, etc. _____
5) Any overnight hospitalizations for illness? ☐ Yes ☐ No If yes, what? _____
   _____
6) Any broken bones? ☐ Yes ☐ No If yes, explain _____
7) Have you ever had a blood transfusion? ☐ Yes ☐ No
8) Up to date on immunizations? ☐ Yes ☐ No
   a. Have you ever served in the Military? ☐ Yes ☐ No
9) Have you ever used HRT (Hormone Replacement Therapy) or Birth Control pills?
   ☐ Yes ☐ No If yes, how long? Date _____ to _____

Surgical History

1) Please list all surgical procedures you have had, and the year operated if known.
   _____ Year: _____
   _____ Year: _____
   _____ Year: _____
   _____ Year: _____
2) Are you allergic to any medications? ☐ Yes ☐ No If yes, please list _____
   _____
3) Do you visit your dentist regularly? ☐ Yes ☐ No

Social History

1) Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long-Term Partner ☐ Widow
2) With whom do you live? _____
3) Current occupation _____ How many hours per week? _____
4) Do you smoke currently? ☐ Yes ☐ No Packs per week? _____ Number of years? _____
5) How many alcoholic beverages do you drink in a week?
   ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ None
6) Do you have or have you ever had addictions(s) to drugs, alcohol or food? ☐ Yes ☐ No
   If yes, explain _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Medical History *(continued)*

Patient Medical History Form

Social History *(continued)*

7) Are you using any illegal medications now? _____
   a. Have you ever been addicted to prescribed, non-prescribed or illegal drugs? ☐ Yes ☐ No
   b. Have you ever been to a rehab program for drug addiction? ☐ Yes ☐ No
8) Have you ever used any Intravenous (IV) drugs? ☐ Yes ☐ No
9) Do you have any history of chemical exposure? ☐ Yes ☐ No If yes, explain _____
   _____
10) Do you have or have you ever had an eating disorder? Ex: anorexia, food obsessions, bulimia, obesity, over-exercising or other(s). ☐ Yes ☐ No If yes, please explain (include if you were treated for it and if so, what treatment)? _____

Family History

1) Is your mother living? ☐ Yes ☐ No If no, at what age did she pass and from what cause? _____
2) Is your father living? ☐ Yes ☐ No If no, at what age did she pass and from what cause?
   _____
3) How many brothers do you have? _____ How many sisters do you have? _____
4) Do any of them have medical issues? ☐ Yes ☐ No If yes, what issues do they have?
   _____
5) Is there a history of cancer in your blood relatives? ☐ Yes ☐ No If yes, who and what type? _____
6) Do you have any relatives who had a heart attack before age 60? ☐ Yes ☐ No
7) Is there any history of diabetes in your family? ☐ Yes ☐ No If yes, who has it and how do they manage it? Ex: diet, medications, etc. _____
8) Are there any other medical problems that tend to run in your family? Ex: graves disease, rheumatoid arthritis, hemochromatosis, alcoholism, etc.? ☐ Yes ☐ No If yes, describe:
   _____

Review of Systems for Females

1) Please write in the total number of times you have been pregnant regardless of the outcome of the pregnancy. _____
2) How many of those resulted in a live birth? _____
3) What was the first day of your most recent menstrual period? _____ Was it normal for you? ☐ Yes ☐ No
4) Have you had a mammogram? ☐ Yes ☐ No If yes, date _____ Last PAP _____
5) Do you suffer from serious discomfort with PMS? ☐ Yes ☐ No
6) Have you received treatment for PMS? ☐ Yes ☐ No If yes, what? _____

GONINO CENTER
for Healing

Medical History *(continued)*

Patient Medical History Form

Stress Index

1) Is your sleep deep and restful? ☐ Yes ☐ No
2) Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No
3) Do you find the stress of life and work difficult to cope with frequently? ☐ Yes ☐ No
4) Do you often feel "drained", "spaced out" or "burned out"? ☐ Yes ☐ No
5) Do you suffer from frequent mood swings? ☐ Yes ☐ No
6) Some of my favorite ways to relax are _____

Nutrition Index

1) Do you take vitamins and/or other nutritional supplements regularly? ☐ Yes ☐ No
2) Do you have any cravings for sugar, bread, alcohol, coffee or soft drinks? ☐ Yes ☐ No
3) Do you eat breakfast regularly? ☐ Yes ☐ No
4) How often do you have a bowel movement? _____

Allergy Index

1) Have you been treated for allergies with drugs? ☐ Yes ☐ No
2) Do you have a pet allergy (cat, dog or others)? ☐ Yes ☐ No
3) Do you have any food, mold, or pollen allergy? ☐ Yes ☐ No
4) Have you been regularly exposed to toxic solvents at work? ☐ Yes ☐ No
5) Do you get more than three attacks of the common cold a year? ☐ Yes ☐ No
6) Have you taken antibiotics more than twice a year? ☐ Yes ☐ No
7) Have you taken cortisone in the last five years? ☐ Yes ☐ No
8) Have you ever suffered from yeast, candida vaginitis, urethritis or prostatitis?
   ☐ Yes ☐ No
9) Are your allergy symptoms worse in spring, summer, winter or fall? _____
10) Are your symptoms worse indoors or outdoors? _____

Fitness Index

1) Do you exercise regularly? ☐ Yes ☐ No If yes, how often and what kind? _____
   _____
2) Describe your general fitness _____
3) Describe your ideal fitness _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Medical History *(continued)*

Patient Medical History Form

Questions for all New Patients (please check all that apply):

- trouble sleeping
- bloody vomit
- trouble swallowing
- night sweats
- urinating at night
- painful urination
- leaking of urine
- joint stiffness
- coughing blood
- ringing in ears
- high blood pressure
- wheezing
- persistent cough
- loss of consciousness
- difficulty speaking
- loss of coordination
- bloody or black tarry stools
- muscle tremor
- excessive tearing
- trouble start/stop urine
- increased frequency of urination
- varicose veins
- significant headaches
- frequent sore throat
- nausea or vomiting
- shortness of breath
- abdominal pain
- difficulty with balance
- any loss of feeling
- persistent hoarseness
- urethral discharge
- head injury
- change in vision
- lesions in mouth
- food intolerance
- heart beating fast
- difficulty with coordination
- decreased appetite
- redness or burning in eyes
- breast tenderness
- blood urine
- frequent urinary tract infections
- palpitations
- muscle pain
- abdominal pain
- eye pain
- dizziness
- hemorrhoids
- swelling
- cough
- constipation
- chills
- hay fever
- ear pain
- skin rashes
- chest pain
- diarrhea
- fever
- indigestion
- breast mass
- weight loss

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Medication & Supplement Chart

Current Medications (include prescription and over the counter)

Medication	Dosage	Instructions	Reason for Use

Nutritional Supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Instructions	Reason for Use

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Medication Management

Medication, Controlled Medication and/or Narcotic Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand the intent of medication is to increase my ability to be more functional and the medication may not completely eliminate the pain but I will communicate fully about the character and intensity of my pain and the effect of the pain on my daily life as well as how well the medicine is helping to relieve the pain.

_____ I promise to disclose any use of any illegal controlled substances, including marijuana, cocaine, etc. to my provider.

_____ I will not take any sedatives, alcohol or other pain medications without prior approval from my doctor and I will not use when I am driving or operating heavy machinery.

_____ I will not share my medication with anyone by selling sharing or in any way distributing to others and I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medication will not be replaced.

_____I will take my medication as instructed and not change the way I take my medication without first talking to the provider.

_____ I will treat the staff at Gonino Center for Healing respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours and provided as written prescriptions only. No refills will be available during evenings or on weekends and no early refills will be approved.

_____I authorize the provider and my pharmacy to cooperate fully with any city, state, or other division/department for my pain medication.

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Medication Management *(continued)*

Medication, Controlled Medication and/or Narcotic Pain Management Agreement

_____ I authorize my provider to provide a copy of the Agreement to my pharmacy, primary care provider, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____ I agree to random drug testing at the request of my provider and at my expense. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for dismissal or discontinuation of my controlled substances.

_____ I agree to schedule an appointment with my physician at either 30, 60, or 90-day intervals. I understand that any no show or cancelled appointment that isn't re-scheduled may result in my prescription not being refilled on time.

_____ I understand that if I break this Agreement, my provider will stop prescribing these controlled medications.

_____ I agree to follow these guidelines that have been fully explained to me.

_____ I agree to use only the pharmacy listed below and if I change pharmacies, I will contact my doctor's office and provide them with the new pharmacy information.

Pharmacy Name _____ Telephone Number _____

Pharmacy Address _____

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. This Agreement is entered into on this _____day of _____ 20_____.

Patient Signature _____ Patient Printed Name _____

Witness Signature _____ Witness Printed Name _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

HIPPA Disclosure Form

Due to the privacy law, we need you to list the people (other than yourself) that you approve to have access to the following healthcare information. If we cannot speak with anyone, please note by writing "no one" in the appropriate blank. You must put something on each line item.

Appointment Scheduling Information

Name _____ DOB _____

Name _____ DOB _____

Billing Information

Name _____ DOB _____

Name _____ DOB _____

Lab/Test Results

Name _____ DOB _____

Name _____ DOB _____

Prescriptions/Medications

Name _____ DOB _____

Name _____ DOB _____

Authorization to Mail Postcards

I authorize Gonino Center for Healing to mail appointment reminder cards, test results and appointment cancellation cards to the address that I currently have on file at the office. This authorization will be in effect until I given written notice to the office to the contrary. _____Yes _____ No

Authorization to Leave or Send Messages

I authorize Gonino Center for Healing to mail, email, and/or leave a message(s) on my phone regarding my medical condition such as lab reports, test results, medications and appointment reminder(s) on any of my contact phone number(s), email address or phone number(s) provided. This authorization will be in effect until I have given written notice to the office to the contrary. _____Yes _____ No

Patient Signature _____ Date _____

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Financial Policy

Thank you for choosing Gonino Center for Healing as your primary care provider. We are committed to your treatment being successful. Please understand that payment of your bill is necessary for us to be able to provide quality care. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Your insurance policy is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. In the event that your insurance coverage changes to a plan where we are not a participating provider, you are responsible for the total balance at each visit.

Co-Payment and Deductibles: All co-payment and deductible must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment and deductibles can compromise our contract. The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

Non-Covered Services: Please be aware that some, and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit. The following services may be considered not covered or not medically necessary; IV therapy, food and environmental allergy testing, microscopy test, massage, sauna & nutritional education services, hyperbaric oxygen, chiropractic, etc. You will be responsible for all services not covered by your carrier.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim(s).

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

Financial Policy *(continued)*

Claims Submission: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We will submit your claims and assist you in any way we are reasonably able. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim regardless of any insurance company's determination of usual and customary rates.

Insurance Coverage Change: If your insurance changes, please notify us before your next visit so we can make the appropriate changes in our system.

Non-Payment: If your account is over 60 days past due, you will receive a letter stating you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from the practice. You will be notified by regular and/or certified mail that you have 30 days to find alternative medical care.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge $70.00 for a missed existing patient appointment and $200.00 for a missed new patient appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or giving 24-hour notice if you need to reschedule.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name (Patient or Responsible Party)

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com

GONINO CENTER
for Healing

Privacy Practices

Notice of Privacy Practices

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Our facility may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. Your records may also be released or exchanged electronically for reasons such as continuity of care. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You may revoke this authorization at any time, in writing, except to the extent that your healthcare facility has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and request a copy of your protected health information (please note there will be a charge for the copy). We will respond to a written request within 30 days under federal law, however you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipating of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Retention regulations allows the clinic to destroy patient medical records after seven years of their last date of service. If the patient is under 18 at the time of service, the records must be kept until the patient's 20th birthday or after the 7th anniversary date of the last treatment, whichever is later.

You have the right to request a restriction of your protected health information. This means you ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information 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. Your request must be made in writing and must describe in a clear and concise fashion the information to be restricted, whether you are requesting to limit our clinic's use, disclosure or both and to whom you want the limits to apply. Gonino Center for Healing is not required to agree to a restriction (45CFR 164.502) that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare facility.

GONINO CENTER
for Healing

Privacy Practices *(continued)*

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

You may have the right to have your healthcare provider amend your protected healthcare information. You may ask us to amend your health information if you believe it is incorrect or incomplete. Your request for amendment must be made in writing and submitted to the Practice Manager. We will respond to your request within 60 days. You must provide us with a reason that supports your request. 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 any such rebuttal.

You have the right to receive an accounting of uses and disclosures we have made, if any, of your protected health information. In order to obtain an accounting of disclosure, you must submit your request in writing to the Practice Manager. It must state a time prior which may not be longer than six years or before January 1, 2014. The first list is free of charge, but our practice may charge for additional lists.

Breach Notification. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have comprised the privacy and security of your information.

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 can file a complaint with the U.S. Dept. of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877- 696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. You may also contact our Operations Administrator. We will not retaliate against you for filing a complaint.

Signature below acknowledges only that you received this Notice of our Privacy Practices.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative

V. John Gonino, D.O.
6720 Horizon Rd • Heath, Texas 75032 • PH 469.402.2800 • FX 469.402.0348
www.goninowellness.com