Gonino Center for Healing

Thank you for choosing Gonino Center for Healing for your healthcare needs. We are looking forward to meeting you and getting you started on your journey to wellness. 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 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 Hwy 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 on your 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 will be more than happy to assist you with alternate route assistance.

"Love Heals"

Gonino Center for Healing

Statement of Philosophy of Dr. John Gonino

I believe that injured and damaged tissues in the human body are healed by nutrients, not drugs.

I believe that when symptoms arise in the body, the reason is secondary to one or more correctable imbalances and/or deficiencies.

The imbalances might have to do with the "flora" in the body, i.e. the healthy bacteria that inhibit the bowel and other areas. Hormonal Imbalance is another area where chronic illness can begin. pH imbalance and energy imbalances all have causes that can be pursued.

I believe that miracles are EVERYONE'S right, but purification is necessary first. Impurities, metals or chemicals, pollute the system and desecrate the altar within.

I believe that it is time for a change in the practice of medicine. People are tired of getting diagnosed with something that has no known cause and no known cure. The cause can be found and corrected if the doctor and patient will work together and be both tireless and patient.

Lastly, I believe that God loves all of his children equally, and that everything that is part of our lives is an opportunity and a gift for us to grown and learn from.

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Gonino Center for Healing

What to Expect at Your Visit

Thank you for your interest in our practice. I want to take a few minutes to let you know what you might expect at your visit. At your first visit, I highly recommend a Microscopy before seeing me. The Microscopy is essential for planning your treatment so that the urgent issues are addressed first. A Microscopy is a live blood cell analysis, dark field, phase contrast microscopy in which a drop of blood is taken from your finger tip and displayed on a TV monitor. Live blood analysis looks at a drop of blood through a high-powered microscope using different conditions of light to help reveal its state. A single drop of blood contains a mass of information indicating nutritional conditions which can be adversely affecting a person's health. If the microscopy is done at your initial appointment, a customized treatment plan will be presented. If you do not already have blood work to provide at your visit, this should be done following your appointment with me. We will provide supplement recommendations that will be made at your initial appointment as well.

I will also highly recommend you attend our nutrition, candida, gluten and breathing class that we hold each Wednesday from 9:00 am until 2:30 pm with a lunch break (you will need to bring your lunch that day). I will personally come in during the lunch break for a brief Q&A session as well share some amazing testimonies. These classes are the foundation of our program. We have learned over the years that patients who attend these classes have a much better result with their treatment than those who do not.

At Gonino Center for Healing we are a big proponent to the many benefits of chiropractic services. We believe correct spinal alignment is critical to long term healing. When there is illness, there is usually also a spinal subluxation.

We have found that most illnesses have at its roots a toxic digestive tract and the most effective and efficient way to heal this is through IV therapy.

I may also recommend a colon detoxifying with a series of colon hydrotherapy treatments and we will provide recommendations of facilities in the area. We have also found that most sick people almost always have a sluggish lymphatic system. There are several recommended treatments for clearing the lymph.

It is my belief that almost all illnesses have at their core an emotional – mental component. Often times our belief systems, even those we are not conscious of can make our bodies stressed. I may recommend counseling.

If you listened to the PH message you know most of us are acidic. When we are acidic, we tend to breathe shallowly which in turn makes us stressed. In these instances, recommended breathing techniques are taught by our yoga instructor.

As well as the already mentioned recommendations, we offer complimentary yoga and tai chi classes twice a week for down regulating exercise are essential to the body. You will receive ongoing wellness coaching from our well trained staff members. Again, thanks so much for choosing Gonino Center for Health for your road to recovery.

I look forward to meeting you,
Dr. John Gonino

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IV Therapies

Please keep in mind that IV's are not covered under insurance plans

Introduction: Either based on your symptoms, existing diagnoses, or what you have witnessed on your live blood analysis, I have recommended one or more intravenous therapies as part of your overall wellness program. The following describes the purpose of each one of these therapies:

Ozone: Ozone is three molecules of oxygen, O3, instead of the usual way that oxygen exists in nature, which is O2. It was first discovered in 1786 and first synthesized in a German Lab in 1840. In 1873 it was discovered that when any micro-organism, ex: viruses, bacteria, tuberculosis, diphtheria were subjected to ozone gas, they were killed. In 1911, Dr, Noble Eberhart, head of the Department of Physiology of Loyola Chicago University used ozone to treat tuberculosis, anemia, pertussis, asthma, bronchitis, diabetes, gout and syphilis. In 1961 Dr. Hans Wolff developed the major and minor auto chemotherapy techniques that we use in our office today. As you may remember from your high school biology class, the majority of energy in your body, called ATP, is produced in the mitochondria of our cells, through a process called electron transport. Oxygen is the final electron receptor in this process. Therefore, if we can increase the oxygen content of the body, this process can occur more efficiently. Circulation is improved with ozone allowing more oxygen to be carried to the tissues. Ozone can improve the immune system, can increase immune response when needed by stimulating white blood cell production and tumor necrosis factor to fight off infection and cancer cells. The immune system can also be quieted by Ozone and ease symptoms of autoimmune diseases like Rheumatoid Arthritis, Crohn's Disease and Lupus. Ozone kills bacteria, viruses, parasites and fungi.

Alpha Lipoic Acid: Alpha Lipoic Acid is the rate-limiting factor for the production of energy from carbohydrate (pyruvate). Without Alpha Lipoic Acid (ALA), you could not obtain energy from the food you eat, and you could not stay alive. Alpha Lipoic Acid (ALA) is also an excellent antioxidant and recycles other nutrients such as CO-Enzyme Q-10, vitamin C and Vitamin E. ALA chelates heavy metals such as mercury, lead, and arsenic. It stabilizes NP kappa B transcription factor so that it helps to inactivate deleterious genes. ALA can also help people with diabetes mellitus by increasing the sensitivity of their cells to insulin, and it helps reverse diabetic neuropathies.

H2O2: This therapy was pioneered by the late Charles Farr M.D., PhD and is now in widespread use in this country. Dr. Farr taught me the proper way to administer this treatment at a seminar he conducted at Genesis Research Institute, Oklahoma City in February of 1997. We have been using it ever since with zero adverse outcomes through June 2009. The principle utility of this treatment is to kill candida in the blood, as well as remove atherosclerotic plaque from your arteries and because it includes vitamins and

minerals. It also strengthens your immune system, similar to IV vitamins. We also perform H2O2 with mineral boost - **EXTRA MINERALS** for hydration.

Glutathione: Glutathione is an amino acid (protein building block) that does a tremendous job repairing liver stress/damage. We often couple this treatment with other supplements, diet, coffee enema, etc. for liver detoxification. We have had outstanding success treating such disease as Chronic Hepatitis C and Cirrhosis, without prescription drugs.

EDTA Chelation: This therapy has been in use since the 1950's for treating lead toxicity. Since that time, many other toxic metals have been found to be able to be removed from the body by this therapy. In addition to removing toxic metals, this treatment also removes plaque from your arteries, and scavenges free radicals that cause cancer. Lastly, as reported in The New England Journal of
Medicine, January 2003, chelation also improves kidney function.

Calcium EDTA: This is a short IV "PUSH" that we often recommend to remove toxins from the blood and body. It does an excellent job; compatible to EDTA. A further "up-side" to this treatment is that it is inexpensive. Unfortunately, you don't get the circulation benefits, removal of plaque, or much improvement in kidney function as you get with EDTA.

DMPS: DMPS acts similar to EDTA in that are another chelating agent (with a different chemical formula). The principle use for DMPS in this office is for those individuals with mercury toxicity.

Diflucan: Diflucan is a prescription antifungal agent that we often use in its oral form to treat candida overgrowth. The principle use of IV Diflucan in this office is to treat tough cases of fungal overgrowth that have not responded to other means (oral antifungals, candida diet, IV H2O2). The upside to this treatment is it treats non-candida fungal species. The downside is that it is somewhat stressful to your liver to metabolize, and it is relatively expensive, compared to IV H2O2 and oral Diflucan.

Zithromax: Zithromax is a prescription antibiotic that we use primarily to treat mycoplasma that we see on microscope exam, or people with positive antibody titers (blood tests) for mycoplasma who have never been treated for it***. Other antibiotics used: Levequin and Rocephin.***

Superoxide dismutase (SOD): This IV antioxidant has shown to produce great improvements in patients with neuralgic disease (multiple sclerosis, ALS-Lou Gehrig's disease, Guillen-Barre Syndrome) as well as various forms of cancer. This is the main antioxidant therapy employed by Robert Bradford, D.S. and colleagues at the Bradford Research Institute in Chula Vista, California. This is the same facility that developed the phase-contrast microscope that we use in office to image your blood.

Artesunate: Artemesia is a plant that grows in the Southeast that Dr. Rowen has used in the past to treat intestinal parasites. It is also considered a safe malaria treatment. When Dr. Rowen discovered a report by Drs. Henry Lai and Narenda Singh, bioengineering professors at the University of Washington that indicated that the herb "might provide a safe, non-toxic, and inexpensive alternative for cancer patients", he started using it with cancer patients. Dr. Lai and his colleague, Dr. Singh, had found its use dramatically killed breast-cancer cells and leukemia cells while leaving normal breast cells and white blood cells unscathed.

Vitamin C: In May of 2006, I attended a conference in Dallas sponsored by the American College for Advancement in Medicine (of which I am a member). One of the speakers at the conference was Mark Levine M.D., presently with the National Institute of Health (NIH) Bethesda, Maryland. Dr. Levine's passion is the use of high dose intravenous vitamin C against various types of cancer. Thus far, his work in laboratory has shown that lymphoma cancer cells, breast cancer cells and kidney cancer cells are totally susceptible (cell surviving rates ranging from 0% surviving cells to 0.3% surviving cells) to the killing effects of vitamin C, without doing absolutely any damage whatsoever to normal body cells. As a side note however, this treatment was not effective against colon cancer cells lines.

Amino Acid: Intravenous Therapies are useful because they bypass the digestive system. Antibiotics, steroids, birth control pills and other toxins that we eat and drink disrupt bowel ecology which blocks to some extent the absorption of nutrients. Amino acids are the building blocks of life. Our body uses 23 amino acids, connected in different patterns to build protein molecules. Why is this important? Because you're whole body is made of protein. It is used in the synthesis of muscle (actin, myosin), skin and connective tissues (collagen), enzymes (digestion of food) and hormones (insulin, growth hormone, thyroid hormone). Amino acids are even used to make neurotransmitters like serotonin, dopamine, adrenaline and GABA, which influence our moods, craving and behaviors. It goes without saying that we need a constant supply of amino acids to maintain optimal health. The problem is many people don't get enough amino acids despite eating abundant amounts. Cancer Amino Acid Treatment works at keeping the body's balance of health-giving amino acids high, and the fast-growth amino acids low. To put it simplistically, all this combines to produce a situation where the body is better able to effectively fight off the disease. Amino acids are extremely important in the treatment of cancer. Dr Thomas Tallberg from Helsinki presented his studies which demonstrated that patients with prostate cancer, leukemia and skin cancer benefited greatly from taking amino acids and other micronutrients. He believes that amino acids should always be included in cancer treatment. Dr. Gonino's primary use of Amino Acids is for "wasting syndrome" for cancer, amyotrophic lateral sclerosis (ALS), and multiple sclerosis (MS).

Albumin: Used for the compensation of low Albumin in patients with congestive heart failure, liver disease, hypothyroidism, celiac disease and many others.

Gonino Center for Healing

Laboratory Tests

These are the standard labs and tests that Dr. Gonino may recommend on your first visit. Some of these tests may not be covered by your insurance plan. However, these tests are essential to your treatment plan to search for the "***root cause of your illness"***.

- **Phase Contrast Microscopy** – This is an examination of your live blood to detect abnormalities such as fungi, parasites, toxins and liver stress. Knowing this information helps us better formulate our treatment plan for you.

- **Standard Labs with or without Lipids** – Includes kidney function, liver function, glucose and A1C, cholesterol, WBC, Hemoglobin, Hematocrit, Comprehensive Metabolic Panel (Chem 14)

- **Glucose-6-phosphate dehydrogenase** – This test is done to make sure that your body can adequately and properly metabolize high doses of Vitamin C IV.

- **Thyroid Panel** – A typical thyroid panel does not give us the adequate amount of information needed to understand how you convert thyroid hormones. Complete thyroid will include:
  a. Complete Thyroid Panel – Free T3, Free T4, Anti-TPO, TgAb and TSH
  b. TSH, Free T4, Free T3, Reverse T3 – "Free" measures what is unbound and usable. RT3 is a hormone that binds your T3 receptors and slows your metabolism. We can teach you ways to reduce it.
  c. Thyroid Antibodies – both are needed: anti TPO and TgAb, which helps us determine if you have an auto immune thyroid issue.
  d. Four Iron – Ferritin, Serum iron, % saturation and TIBC – High Ferritin can point to high inflammation, high ferritin/serum iron/% saturation can point to hemochromatosis, a genetic mutation. <u>High serum iron and low ferritin can point to a MTHFR</u> mutation.
  e. Saliva Adrenal Cortisol (ZRT) – Measures stress hormones and how cortisol differs throughout the day.
  f. B-12, Cortisol, DHEA, Iodine – Brain Hormones, Sex Hormones, Adrenal Hormones and Thyroid. Iodine is the major cofactor and stimulator for Thyroid peroxidase (TPO) which converts one of your thyroid hormones, T4 to the active form, T3.
  g. RBC Magnesium, Potassium, Sodium (in Chem 14 if done) – Assess true Magnesium deficiency levels. The body's minerals can go too low with Hypothyroidism.

- **Heavy Metal Test** –A Heavy Metal test is a 24 hour urine test, after a short IV push called EDTA chelation. We have seen many people at panic levels for heavy metals because toxins are in our water, our air and everyday foods. Some people do not readily expel toxins and they embed themselves in our major organs, wreaking havoc. We can subsequently remove these toxins via EDTA chelation and DMPS (Di-Mercapto-Propanesulfonic Acid-Sodium) given intravenously.

- **MTHFR** – It is a genetic defect that reduces the body's ability to detox itself by 30 – 70 percent, depending on the variant inherited. 85% of the population has some variation of the mutation, and most don't even know they have it. Dr. Gonino recommends this test because the body is unable to detox itself properly, things like heavy metals, fungus,

Laboratory Tests Page 2

chemicals and histamines build up causing inflammation. MTHFR is an enzyme involved in the metabolism of folate and homocysteine. It plays a role in mainaining cellular folate levels and is a cofactor needed to convert homocysteine to methionine.

- **Homocysteine** – Homocysteine levels when elevated, are known independent risk factors for development of cardiovascular disease and related heart and BP conditions, we well as increasing your risk for dementia and inflammation in your arteries. Fortunately, we have seen great results in lowering homocysteine levels using Homocystex Plus, Moly B, and NAC.

These are the additional "alternative" lab tests we do at our office. Some of these tests may not be covered by your insurance plan. However, these tests are essential to your treatment plan to search for the "***root cause of your illness".***

- **Mycoplasma** – This is a fast multiplying bacteria in the blood that causes many auto immune diseases and cancers by the extreme weakening of the immune system. This test is important for cancer patients, and anyone with pain, fibromyalgia or thyroid diseases. If a person tests positive for this and is not aware if they have been treated for it or not, we typically recommend treatment with IV Zithromax.

- **Nagalase** – This test is used to identify the activity of the enzyme called Nagalase that helps cancer cells hide from the immune system. The Nagalase enzyme has the ability to completely shut down the activity of the localized immune macrophage cell, whose job it is to destroy any cell that has been harmed or is not functioning normally. This is the reason that someone can have a strong functioning immune system and still be growing a tumor. Dr. Gonino uses this test to check the progress of treatment instead of doing CT Scans.

- **Galectin-3** – If Galectin 3 is abnormal, you are more than likely feeding cancer cells. Galectin 3 promotes cancer in 3 ways. It allows cancer cells to attach to one another foring groups that can survive in your blood stream and migrate to other parts of your body. Once cancer cells have formed a primary tumor, Galectin 3 helps them aggregate and grow, and attach themselves to new sites as well, forming secondary tumors. Galectin 3 at high levels supplies nutrients to malignant tumors by stimulating new vessel growth even when there was no growth prior. Fortunately, high Galectin 3 levels can be modulated with Pectasol-C.

- **Organic Acid Test** – Organic Acids Test (OAT) provides accurate evaluation of intestinal yeast and bacteria. Abnormally high levels of these microorganisms can cause or worsen behavior disorders, hyperactivity, movement disorders, fatigue and immune function. Many people with chronic illnesses and neurological disorders often excrete several abnormal organic acids in their urine. Oxalates are small molecules that form crystals. The human body also produces them as a waste product. Oxalates are poisonous to the human body and are considered a waste product. The value or OAT with Great Plains Laboratory, is to test for oxalates and all the DNA/metabolism factors that contribute to oxalates, Vitamin B6 and markers associated with genetic forms of oxalate problems.

- **Viral Panel "EBV" –** Once you have had the Mononucleosis Virus, you will carry the virus forever. Mono is known as the kissing disease because it is transmitted through saliva. EBV flare ups occurs when the immune system becomes suppressed. Typical symptoms of EBV are sore throat, swollen glands, muscle aches, pains and fatigue.

Laboratory Tests Page 3

- **H.Pylori** – H Pylori is a stomach bacteria that can be contracted from contaminated water or certain foods. This can cause abdominal pain, heartburn and digestive issues as well as stomach ulcers and rarely stomach cancer. Patients who are experiencing severe bowel and digestive issues, should be tested. Again, fortunately, there is treatment for this issue if it is discovered.

- **CDSA Stool Analysis – The Comprehensive Digestive Stool Analysis (CDSA)** offers a comprehensive look at the overall health of the gastrointestinal (GI) tract. This stool analysis evaluates digestion/absorption markers, gut metabolic markers, probiotic strains, parasites and bacteria.

- **Lyme AB Screen** – Antibody test is used to determine if you have been infected with Borrelia Burgdorferi (tick bite); the bacterium that causes Lyme disease. Typical symptoms include fever, headache, fatigue, and a characteristic skin rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system.

- **Spectrox** – This is a total antioxidant function test that assesses the ability of cells to resist damage caused by free radicals and other forms of oxidative stress. SPECTROX is the most accurate and clinically useful way to assess total antioxidant function which will tell us what nutrients your body is deficient in.

- **Food and Environmental Allergy Testing –** Has it ever occurred to you that fatigue, weight gain, abdominal discomfort, headaches, even aging skin could be due to a food allergy? Consideration of food allergy is a critical component of any comprehensive approach to good health. Patients who are not getting better on the program will usually have leaky gut syndrome due to allergy issues.

- **Gluten Gene DQ2 and DQ8 –** In our office, we believe that all of the autoimmune diseases are directly caused by an immune response to gluten in genetically predisposed individuals. Although patients may be asymptomatic, infants and young children commonly present with diarrhea, failure to thrive, abdominal pain and distension. Older children and adolescents may exhibit extra intestinal symptoms including short stature, delayed puberty, anemia, and neurological symptoms caused by nutrient malabsorption. In up to 50% of adults, the presenting problem is diarrhea, which may be accompanied by abdominal pain or discomfort. Most insurances pay for what Dr. Gonino calls the "outdated gluten tests" (anti-gliaden and endomysial antibody testing). Our genetic test will tell you if you have the propensity to develop ANY type of autoimmune disease, not just Celiac. Having said all of that, if Dr. Gonino and/or our Advanced Practitioners have a strong suspicion that you carry the gene (fair skin, blue eyes, reddish or blonde hair, freckles, long thick eyelashes, or a family history of an autoimmune disease – ex. Lupus, Lou Gehrig's, Crohn's, Ulcerative Colitis, Rheumatoid arthritis, Sjogren's etc.) they are likely to recommend saving your money and using it for other aspects of our program. However, if you want definitive proof that you carry any of the genes that code for gluten sensitivity, this test is available to you. Be advised that without a 1st degree relative with Celiac disease or without a personal history of diarrhea or bloody diarrhea, your insurance is not likely to cover the cost.

- **Vitamin D** – 1,25 (OH) Vitamin D3: Active & 25 (OH) Vitamin D3: Inactive. Vitamin D helps offset the lack of sunshine during the winter, cold months when depression or melancholy sets in and the immune cells gets sluggish. When physicians talk about vitamin D deficiency, they

are invariably talking about the low levels of a compound called hydroxyvitamin D 25 or "25 (OH) Vitamin D3" which is inactive. Our kidney normally converts D from inactive 25 form, to the active 1,25 form, and magnesium is necessary for that conversion. Drug muggers that steal magnesium (such as acid blockers, diuretics and steroids) can hinder the conversion process. Additionally, kidney disease or reduced kidney function means suppressed vitamin D activity and thus, reduced 1,25 levels of the active form. As much as I love vitamin D, toxicity can occur if you take very high doses. Some of the symptoms include: heart palpitations, nausea, constipation, kidney stones, memory loss, softening of bones, hyperparathyroidism and body aches. 90% of our patient population is Vitamin D deficient.

- **DAO (Dunwood Labs) –** (Advanced Intestinal Barrier Assessment 5150* includes Diamine Oxidase (DAO), Histamine and Zonulin) is a test we use to see how well your body is reacting to our treatment and supplement(s). Diamine oxidase is an enzyme that breaks down histamine. Histamine is a compound that affects immune response, physiological function of the digestive tract, and acts as a neurotransmitter. Zonulin is a eukaryotic protein structurally similar to Vibrio cholerae's zonula occludens toxin. It plays an important role in the opening of small intestine tight junctions.

- **Glyphosate –** Great Plains Laboratory –Glyphosate is important to test because it gets into our bones, brains and bowels. Direct exposure by using herbicides, such as through skin contact or breathing herbicide residue. Eating fruits/vegetables, eating animals that were fed vegetables with glyphosate residue can also be harmful.

Gonino Center for Healing
Weekly Food Intake

WEEKLY FOOD INTAKE JOURNAL: Please log your daily food intake and let us know if this is a typical day for you or not.

	Breakfast	**Lunch**	**Dinner**	**Snacks**	**Drinks**	**Other**
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

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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.

1) Main reason for visit:
_____
_____

2) 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:_____
_____

3) Are you taking medication that you wish to get off of? If so, please indicate the name of the medication/s:_____

And what are you taking them for?:_____
_____

What reaction(s) if any, have you experienced with this medication:_____
_____

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

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Patient Questionnaire
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Patient Name: _____ DOB: ____/____/_____

5) What natural remedies are you currently using?:_____
_____

6) Are you receiving treatment such as Acupuncture, Chiropractic, Ozone therapies, Infrared Therapies, Colonics, etc. by another Physician/Practitioner? _____ YES _____ NO

If yes, please describe:_____

Cancer Patient Questionnaire Only Below:

1) Have you ever had chemotherapy or radiation? _____ YES _____ NO
   If NO, why? _____

2) Are you currently under the care of an Oncologist? _____ YES _____ NO
   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

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Authorization to Release Medical Records

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

_____ Complete Medical Record

_____ Records of care from the following dates: _____ to _____

_____ Records of care concerning the following condition/s:_____

_____ Other, please specify:_____

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 _____

Release information **TO**:

Name/Facility: V. John Gonino DO, PA 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

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Hormone Imbalance Questionnaire

Hormonal balance is a foundation for good health. It is your hormones that support all major bodily organs and functions, such as bone, muscle, joints, digestive organs, brain, skin and heart. In addition, hormonal balance is necessary for a person's emotional well-being, energy level and immune system. Long-term effects of hormonal depletion and dysfunction (imbalance) are pre-mature aging, heart disease, osteoporosis, arthritis, and higher risk of cancer. Please take the hormonal balance questionnaire to see if you may be experiencing symptoms of hormonal imbalance.

1. What is your gender?
   O Female O Male
2. Have you ever taken birth control?
   O Yes O No If yes, when?_____ How long?_____
3. Have you ever used Bioidentical Hormone Replacement?
   O Yes O No If yes, when?_____ How long?_____
4. Have you ever used HRT (Hormone Replacement Therapy)?
   O Yes O No If yes, when?_____ How long?_____
5. Do you experience hot flashes?
   O Always O Often O Sometimes O Rarely O Never
6. Do you experience night sweats?
   O Always O Often O Sometimes O Rarely O Never
7. Do you experience irregular periods/menstrual irregularities?
   O Always O Often O Sometimes O Rarely O Never
8. Do you feel you suffer from a loss of libido (sex drive)?
   O Always O Often O Sometimes O Rarely O Never
9. Do you experience vaginal dryness or loss of tone?
   O Always O Often O Sometimes O Rarely O Never
10. Do you feel you suffer mood changes such as irritability, depression or anxiety?
    O Always O Often O Sometimes O Rarely O Never
11. Do you feel you experience fatigue?
    O Always O Often O Sometimes O Rarely O Never
12. Have you experienced hair loss anywhere on your body?
    O Always O Often O Sometimes O Rarely O Never
13. Do you feel you suffer from a sense that you aren't getting enough sleep?
    O Always O Often O Sometimes O Rarely O Never
14. Do you experience memory lapses?
    O Always O Often O Sometimes O Rarely O Never

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Hormone Imbalance Questionnaire
Page 2

15. Have you been putting on weight more easily than usual?
    O Yes O No
16. Do you experience difficulty concentrating and a sense of disorientation?
    O Always O Often O Sometimes O Rarely O Never
17. Do you experience dizziness, light-headedness or episodes of loss of balance?
    O Always O Often O Sometimes O Rarely O Never
18. Do you experience incontinence, particularly from sneezing, laughing or urge incontinence?
    O Always O Often O Sometimes O Rarely O Never
19. Do you suffer from sudden bouts of bloating?
    O Always O Often O Sometimes O Rarely O Never
20. Have you experienced an increase in any allergies?
    O Yes O No
21. Do your finger or toenails crack or break more easily?
    O Yes O No
22. Have you experienced any changes in body odor?
    O Yes O No
23. Do you experience a racing/irregular heartbeat?
    O Always O Often O Sometimes O Rarely O Never
24. Do experience bouts of depression?
    O Always O Often O Sometimes O Rarely O Never
25. Have you experienced an increase in your anxiety level?
    O Yes O No
26. Do you feel you are more irritable than usual?
    O Always O Often O Sometimes O Rarely O Never
27. Have you been feeling breast pain?
    O Yes O No
28. Do you experience aching, sore joints, muscles/tendons?
    O Always O Often O Sometimes O Rarely O Never
29. Do you experience a "crawling" sensation under the skin?
    O Always O Often O Sometimes O Rarely O Never
30. Do you experience digestive problems, gastrointestinal distress, indigestion, gas pain, flatulence or nausea?
    O Always O Often O Sometimes O Rarely O Never
31. Do you experience gum problems or bleeding?
    O Always O Often O Sometimes O Rarely O Never
32. Do you experience increased tension in your muscles?
    O Always O Often O Sometimes O Rarely O Never

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Candida Questionnaire – Page 1

Section A: History

Instructions: For each yes answer in section A, circle the Point Score in that section. Total your score and record it at the end of the section. Then move on to sections B and C, scoring as directed.

1.	Have you taken tetracycline (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotic for acne for 1 month or longer?	50
2.	Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory or other infections for 2 months or longer, or in shorter courses 4 or more times in a 1 year period?	50
3.	Have you ever taken a "broad spectrum" antibiotic drug-even for one period?	6
4.	Have you ever been bothered by persistent prostatitis, vaginitis or other problems that affect your reproductive organs?	25
5.	Have you ever been pregnant – 2 or more times?	5
	1 time?	3
6.	Have you taken birth control pills for – more than 2 years?	15
	6 months to 2 years?	8
7.	Have you taken prednisone, Decadron or other cortisone type drugs for- more than 2 weeks?	15
	2 weeks or less?	6
8.	Does exposure to perfumes, insecticides, fabric shop odors or other Chemicals provoke – moderate to severe symptoms?	20
	Mild symptoms?	5
9.	Are symptoms worse on damp, muggy days or in moldy places?	20
10.	Have you had athletes foot, ringworm, "jock itch" or other chronic fungous infections of the skin or nails – moderate to severe?	20
	Mild to moderate?	10
11.	Do you crave sugar?	10
12.	Do you crave breads or other foods high in carbohydrates?	10
13.	Do you crave alcoholic beverages?	10
14.	Does tobacco smoke really bother you?	10

Total Score from Section A _____

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Candida Questionnaire-Page 2

Section B: Major Symptoms

Instructions: For each symptom that is present, circle the appropriate number in the Point Score Column.

If a symptom is occasional or mild……..….score 3 points
If a symptom is frequent and/or moderately severe…….score 6 points
If a symptom is severe and/or disabling…….score 9 points

Total the score and record it at the end of this section.

		Point Score
1.	Fatigue or lethargy	3 / 6 / 9
2.	Feeling of being "drained"	3 / 6 / 9
3.	Poor memory	3 / 6 / 9
4.	Feeling "spacey" or "unreal"	3 / 6 / 9
5.	Depression	3 / 6 / 9
6.	Numbness, burning or tingling	3 / 6 / 9
7.	Insomnia	3 / 6 / 9
8.	Muscle aches	3 / 6 / 9
9.	Muscle weakness or paralysis	3 / 6 / 9
10.	Joint pain or swelling	3 / 6 / 9
11.	Abdominal pain	3 / 6 / 9
12.	Constipation	3 / 6 / 9
13.	Diarrhea	3 / 6 / 9
14.	Bloating, belching or intestinal gas	3 / 6 / 9
15.	Troublesome vaginal burning, itching or discharge	3 / 6 / 9
16.	Prostatitis	3 / 6 / 9
17.	Impotence	3 / 6 / 9
18.	Loss of sexual desire or feeling	3 / 6 / 9
19.	Endometriosis or infertility	3 / 6 / 9
20.	Cramps and/or other menstrual irregularities	3 / 6 / 9
21.	Premenstrual tension	3 / 6 / 9
22.	Attacks of anxiety or crying	3 / 6 / 9
23.	Cold hands or feet and/or chilliness	3 / 6 / 9
24.	Shaking or irritable when hungry	3 / 6 / 9

Total Score from Section B _____

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Candida Questionnaire-Page 3

Section C: Other Symptoms

Instructions: For each symptom that is present, circle the appropriate number in the Point Score Column. Total the score and record it at the end of this section.
If a symptom is occasional or mild……..…..score 3 points
If a symptom is frequent and/or moderately severe……..score 6 points
If a symptom is severe and/or persistent…….score 9 points

		Point Score
1.	Drowsiness	3 / 6 / 9
2.	Irritability or jitteriness	3 / 6 / 9
3.	Incoordination	3 / 6 / 9
4.	Inability to concentrate	3 / 6 / 9
5.	Frequent mood swings	3 / 6 / 9
6.	Headache	3 / 6 / 9
7.	Dizziness/loss of balance	3 / 6 / 9
8.	Pressure above ears, feeling of head swelling and/or tingling	3 / 6 / 9
9.	Tendency to bruise easily	3 / 6 / 9
10.	Chronic rashes or itching	3 / 6 / 9
11.	Psoriasis or recurrent hives	3 / 6 / 9
12.	Indigestion or heartburn	3 / 6 / 9
13.	Food sensitivity or intolerance	3 / 6 / 9
14.	Mucus in stools	3 / 6 / 9
15.	Hemorrhoids or rectal bleeding	3 / 6 / 9
16.	Dry mouth or throat	3 / 6 / 9
17.	Rash or blisters in mouth	3 / 6 / 9
18.	Bad breath	3 / 6 / 9
19.	Foot, hair or body odor not relieved by washing	3 / 6 / 9
20.	Nasal congestion, discharge or post nasal drip	3 / 6 / 9
21.	Nasal itching	3 / 6 / 9
22.	Sore or dry throat	3 / 6 / 9
23.	Laryngitis, loss of voice	3 / 6 / 9
24.	Cough or recurrent bronchitis	3 / 6 / 9
25.	Pain or tightness in chest	3 / 6 / 9
26.	Wheezing or shortness of breath	3 / 6 / 9
27.	Urgency, frequency or incontinence	3 / 6 / 9
28.	Burning on urination	3 / 6 / 9
29.	Spots in front of eyes or erratic vision	3 / 6 / 9
30.	Burning or tearing of eyes	3 / 6 / 9
31.	Recurrent infections of fluid in ears	3 / 6 / 9
32.	Ear pain or deafness	3 / 6 / 9

Total Score from Section C _____

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Candida Questionnaire-Page 4

Test Scoring and Results

Total Score from Section A _____

Total Score from Section B _____

Total Score from Section C _____

Grand Total Score (add sections A, B and C above for total) _____

The Grand Total Score will help you and your health care provider decide if your health problems are yeast-connected. Scores for women will typically run higher.

Yeast-connected health problems are almost certainly present in women with scores over **180** and in men with scores over **140**.

Yeast-connected health problems are probably present in women with scores over **120** and in men with scores over **90**.

Yeast-connected health problems are possibly present in women with scores over **60** and in men with scores over **40**.

With scores less than **60** for women and **40** for men, yeast will be less apt to cause health problems.

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Gluten Questionnaire

Gluten intolerance has been found to be the most common of people of Irish, English, Scottish, Scandinavian and Eastern European descent. Often times it is assumed that gluten intolerance is a food allergy, but it is not. It is actually an autoimmune process which affects an alarming percentage of the population. The most significant symptoms are weight gain, fatigue and depression. The following test is a diagnostic tool to help you to understand the signs and symptoms that are likely to go along with gluten intolerance.

Name:_____ DOB:_____

Do any of the following apply to you? Circle answer

Yes / No	Weight Gain
Yes / No	Unexplained fatigue
Yes / No	Difficulty relaxing, feel tense frequently
Yes / No	Unexplained digestive problems
Yes / No	Female hormone imbalances (PMS, menopausal symptoms)
Yes / No	Muscle or joint pain or stiffness of unknown cause
Yes / No	Migraine like headaches
Yes / No	Food allergies/sensitivities
Yes / No	Difficulty digesting dairy products
Yes / No	Tendency to over consume alcohol
Yes / No	Overly sensitive to physical and emotional pain, cry easily
Yes / No	Cravings for sweets, breads, carbohydrates
Yes / No	Tendency to overeat sweets, breads, carbohydrates
Yes / No	Abdominal pain or cramping
Yes / No	Abdominal bloating or distention
Yes / No	Intestinal gas
Yes / No	"Love" specific foods
Yes / No	Eat when upset, eat to relax
Yes / No	Constipation or diarrhea of no known cause
Yes / No	Unexplained skin problems/rashes
Yes / No	Difficulty gaining weight

Have you suffered from any of the following conditions? Circle answer

Yes / No	Allergies
Yes / No	Depression
Yes / No	Anorexia
Yes / No	Bulimia
Yes / No	Rosacea
Yes / No	Diabetes
Yes / No	Osteoporosis/bone loss
Yes / No	Iron deficiency/anemia
Yes / No	Chronic fatigue
Yes / No	Irritable bowel syndrome
Yes / No	Crohn's disease
Yes / No	Ulcerative colitis
Yes / No	Candida
Yes / No	Hypoglycemia
Yes / No	Lactose intolerance
Yes / No	Alcoholism

Combining both sections, total up the number of "Yes" responses: _____

4 or less = No Likely
5 – 8 = Suspected
9 or more = Very Likely

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Patient Questionnaire

Do I Have MTHFR Deficiency?

Are you wondering, "Do I have MTHFR deficiency?"

If you answer yes to 5 or more of these questions, then you may have a genetic condition called MTHFR deficiency.

Do you experience any of these symptoms of MTHFR deficiency?

Circle answer below:

Yes / No I get frustrated more easily than I think I should
Yes / No I get angry when I know that I shouldn't
Yes / No I have a hard time sleeping at night
Yes / No I feel anxious
Yes / No I get overwhelmed too easily
Yes / No I have many angry thoughts; I get upset if things are not the way I think they should be
Yes / No I will do whatever it takes to correct a difficult situation
Yes / No I am great when there is no stress, but when things do not go right I get stressed out and can get angry
Yes / No I have an addiction (drugs, alcohol, food, work, sex, computers, gambling, etc.)
Yes / No I feel fear when faced with a new situation
Yes / No I have been diagnosed with heart disease
Yes / No I have irritable bowel syndrome
Yes / No I have or have been told that I have PMS
Yes / No I have had at least one miscarriage

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

PATIENT REGISTRATION FORM

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:_____ SS#:_____ Contact #:_____

Address if different from patient:_____

Employer:_____ Contact #:_____

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Patient Registration – Page 2

Employer Address:_____

Policy ID #:_____ Policy Group #:_____

Copay Amount:_____ Deductible Amount:_____

Secondary Insurance Plan:_____ Policy Holder Name:_____

Relationship to patient: _____ Self _____ Spouse _____ Child _____ Other

Policy Holder DOB:_____ SS#:_____ Contact #:_____

Address if different from patient:_____

Policy ID #:_____ Policy Group #:_____

Copay Amount:_____ Deductible Amount:_____

APPOINTMENT POLICY NOTIFICATION:

I, _____, am aware of the policy that went into effect February 24, 2009 stating 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 30 minute appointment and $70.00 for missing a 15 minute 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:_____

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Gonino Center for Healing
Patient Consent

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:_____
If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legal authorized representative of the Patient.

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Gonino Center for Healing
PATIENT PAST MEDICAL HISTORY FORM

PAST 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, who?_____
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? ___ If yes, what?_____
6. Any broken bones?_____
7. Ever had a blood transfusion?_____
8. Up to date on immunizations?_____
   a. As a child, how many?_____ What?_____
   b. Military, how many?_____ What?_____
   c. Mission or humanitarian work, how many?_____ What?_____
   d. Flu shots? Yes / No
   e. Any other vaccinations for Shingles, Pneumonia, etc? Explain:_____
9. Have you ever used HRT (Hormone Replacement Therapy) or Birth Control pills? Yes / No If yes, how long? Date_____ to _____

PAST SURGICAL HISTORY:

Please list all surgical procedures you have had and the year operated if known.

_____ Year:_____
_____ Year:_____
_____ Year:_____
_____ Year:_____

10. Are you allergic to any medications? Yes / No If yes, please list:_____
    a. What meds to you take on a daily basis?_____
11. Do you visit your dentist regularly? Yes / No

SOCIAL HISTORY:

1. Are you married?_____ single?_____ divorced?_____ How long?_____
2. Who lives in your home besides yourself?_____
3. What do you do for a living?_____ How many hours per week?_____
4. Do you smoke? Yes / No If yes, how many packs per week?_____
5. How much alcohol do you drink?_____
6. Do you have or ever had addiction(s) (drug, alcohol, food) If yes, explain?_____
7. Are you using any illegal medications now?_____
   a. Have you ever been addicted to prescribed, non-prescribed or illegal drugs?_____
   b. Have you ever been to a rehab program for drug addiction?_____
8. Have you ever used any I.V. drugs?_____
9. Do you have any history of chemical exposure? _____

10. Do you have or ever had an eating disorder? Ex: anorexia, food obsessions, bulimia, obesity, over-exercising or other(s). If so, please explain if you were treated for it and what treatment did you have?_____

FAMILY HISTORY:

1. Is your mother living? Yes / No If no, at what age did she die and from what cause? _____
2. Is your father living? Yes / No If no, at what age did he die 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 problems 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 to 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.? 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 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?_____

STRESS INDEX:

1. Is your sleep deep and restful?_____
2. Do you find the stress of life and work difficult to cope with frequently?_____
3. Do you often feel "drained", "spaced out" or "burned out"?_____
4. Do you suffer from frequent mood swings?_____
5. Some of my favorite ways to relax are?_____

NUTRITION INDEX:

1. Do you take vitamins and/or other nutritional supplements regularly?_____
2. Do you have any craving for sugar, bread, alcohol, coffee or soft drinks?_____
3. Do you eat breakfast regularly?_____
4. How often do you have a bowel movement?_____

Page 3

ALLERGY INDEX:

1. Have you been treated for allergies with drugs?_____
2. Do you have a pet allergy (cat, dog or others)?_____
3. Do you have any food, mold, or pollen allergy?_____
4. Have you been regularly exposed to toxic solvents at work?_____
5. Do you get more than three attacks of the common cold a year?_____
6. Have you taken antibiotics more than twice a year?_____
7. Have you taken cortisone in the last five years?_____
8. Have you ever suffered from yeast, candida vaginitis, urethritis or prostatitis?_____
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?_____

QUESTIONS FOR ALL NEW PATIENTS:

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

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Medication Chart

Name of Medication	Dosage (total milligrams)	How many times per day?	When do you take it? (Ex. morning, after meals, etc.)	Who prescribed it for you? (physician's name)	What are you taking it for?	Do you have any side effects? Describe them.
Name of Supplement	**Dosage (total milligrams)**	**How many times per day?**	**When do you take it? (Ex. morning, after meals, etc.)**	**Who recommended it for you? (provider's name)**	**What are you taking it for?**	**Do you have any side effects? Describe them.**

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Narcotic Pain Management Agreement

The purpose of the 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 do more 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 will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances.
- 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 and a police report will be required.
- 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 diversion of my pain medication. 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.
- I agree to schedule an appointment with my physician at either 30, 60, or 90 day intervals.
- I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.
- 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:_____

Provider Signature:_____ Provider Printed Name:_____

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HIPAA 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 can NOT speak with anyone, please note by writing "NOONE" in the appropriate blank. You must put something on each line item.

Appointment Scheduling Information:_____ DOB:_____
_____ DOB:_____

Billing Information:_____ DOB:_____
_____ DOB:_____

Lab/Test Results:_____ DOB:_____
_____ DOB:_____

Prescriptions/Medications:_____ DOB:_____
_____ 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 have 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 an 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 contract. _____ Yes _____ No

Patient Signature:_____ Date:_____

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Gonino Center for Healing

FINANCIAL POLICY

Thank you for choosing Gonino Wellness Group 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 we do business with, payment in full is expected at each visit. If you are insured by 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. You will be responsible for all services not covered by your carrier.

Proof of insurance: Al 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 a claim.

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 reasonably can to help get responsibility to comply with their request. 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 15-minute appointment, & $200.00 for a missed 30-minute 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 re-schedule.***

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

_____ _____

Signature of patient or responsible party Date

"Love Heals"

Experience Health
6720 Horizon Rd ● Heath, Texas 75032 ● PH 469.402.2800 ● FX 469.402.0348
www.goninowellness.com

Gonino Center for Healing
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.
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 you 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 use 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 Practice Manager. We will not retaliate against you for filing a complaint.**

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

_____ _____

Signature and printed name of patient or representative **Date**