



## Directions

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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 3<sup>rd</sup> 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 3<sup>rd</sup> 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](http://www.goninowellness.com)



## Gonino Center for Healing Philosophy

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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.

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## Welcome

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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

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## Intravenous (IV) Therapies

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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

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## Patient Questionnaire

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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? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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## Patient Questionnaire *(continued)*

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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



## Medical Records

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### 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	<b>Gonino Center for Healing</b>
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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## Patient Registration Form

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### 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 \_\_\_\_\_

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## Patient Registration Form *(continued)*

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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 \$250.00 for missing a new patient appointment and \$85.00 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

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## Patient Consent

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### 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 \_\_\_\_\_

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## Medical History

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### 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 \_\_\_\_\_

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## Medical History *(continued)*

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### 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? \_\_\_\_\_

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## Medical History *(continued)*

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### 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 \_\_\_\_\_

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## Medical History *(continued)*

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### 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

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## Medication & Supplement Chart

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**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

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## Medication Management

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### 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.

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## Medication Management *(continued)*

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### 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 \_\_\_\_\_

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## HIPPA Disclosure Form

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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**

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## Financial Policy

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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).

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## Financial Policy *(continued)*

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**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 \$85.00 for a missed existing patient appointment and \$250.00 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)

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## Privacy Practices

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### 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 anticipation 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 20<sup>th</sup> birthday or after the 7<sup>th</sup> 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.

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## Privacy Practices *(continued)*

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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](http://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

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