Integrated Spine, Pain & Wellness
DR. ASHU GOYLE

Patient Name:_____ **Chief Complaint:** _____

Pain Description

What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin?
☑ Gradually ☐ Suddenly

Since your pain began, how has it changed?
☐ Decreased ☐ Increased ☐ Stayed the same

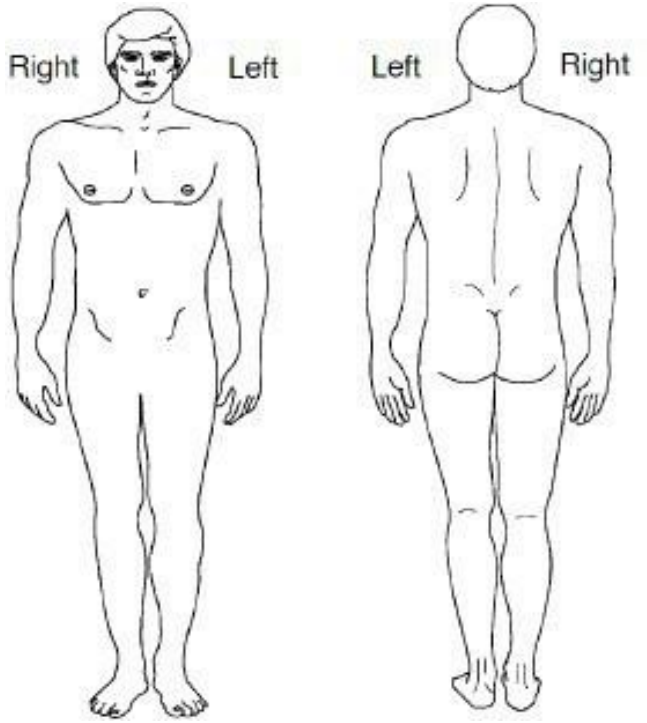
Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles "A" = aching



Pain Description - Check all of the following that describe of your pain:

☐ Aching	☐ Numbness	☐ Spasming	☐ Throbbing
☐ Cramping	☐ Shock-like	☐ Squeezing	☐ Tingling/Pins & Needles
☐ Dull	☐ Shooting	☐ Stabbing/Sharp	☐ Tiring/Exhausting
☐ Hot/Burning			

Pain Frequency

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

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Patient Name: _____

Mark all of the following activities that are adversely/negatively affected by your pain

- ☐ Enjoyment of Life
- ☐ General Activity
- ☐ Mood
- ☐ Normal Work
- ☐ Recreational Activities
- ☐ Relationship with people
- ☐ Sleep
- ☐ Walking
- ☐ Other: _____

Diagnostic Tests and Imaging

- ☑ MRI of the _____ Date: _____ Facility: _____
- ☐ X-ray of the _____ Date: _____ Facility: _____
- ☐ CT scan of the _____ Date: _____ Facility: _____
- ☐ EMG/NCV study of the _____ Date: _____ Facility: _____
- ☐ Ultrasound of the _____ Date: _____ Facility: _____
- ☐ Other diagnostic testing: _____

☐ **I Have Not Had Any Diagnostic Tests Performed for My Current Pain Complaints**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

	Beneficial	
☑ Chiropractic	Yes	No
☐ Physical Therapy	Yes	No
☐ Psychological Therapy	Yes	No
☐ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Joint Injection – Joint(s) _____	Yes	No
☐ Medial Branch Blocks or Facet Injections (circle all levels that apply) Cervical/Thoracic/Lumbar		
☐ Nerve Blocks – Area/Nerve(s) _____	Yes	No
☐ Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant	Yes	No
☐ Spine Surgery	Yes	No
☐ Trigger Point Injection – Where? _____	Yes	No
☐ Vertebroplasty / Kyphoplasty – Level(s) _____	Yes	No
☐ Other: _____	Yes	No

☐ **I Have Not Had Any Prior Treatments for My Current Pain Complaints**

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐ No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐ No

If yes, please explain: _____

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Patient Name: _____

Current Medications

Are you taking a prescribed **blood-thinner** medication? ☐ Yes ☐ No If yes, please check which one:

Prescribing Physician: _____

☐ Aggrenox ☐ Coumadin / Warfarin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pleta ☐ Pradaxa ☐ Ticlid

☐ Heparin ☐ Xarelto ☐ Arixta ☐ Aspirin ☐ Advil, Aleve other NSAIDS

☐ Herbal Supplements _____

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name:	Allergic Reaction Type:

Please check if you are allergic to ☐ Iodine or ☐ Tape **Are you allergic to shellfish**? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Patient Name:

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ HIV / AIDS
- ☐ Kidney Disease

Head/Eyes/Ears/Nose/Throat

- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Migraines
- ☐ Sinusitis
- ☐ Hearing Loss
- ☐ Snoring

Gastrointestinal

- ☐ Bowel Incontinence
- ☐ Acid Reflux (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation
- ☐ Opioid Induced Constipation

Respiratory

- ☐ Asthma
- ☐ Emphysema / COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ PE
- ☐ Obstructive Sleep Apnea

Musculoskeletal

- ☐ Amputation
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid arthritis
- ☐ Vertebral Compression Fracture
- ☐ Reflex Sympathetic Dystrophy/CRPS

Cardiovascular / Hematologic

- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Murmur
- ☐ Pacemaker/Defibrillator
- ☐ Poor Circulation
- ☐ Stroke

Neuropsychological

- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Prescription Drug Abuse
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures

Past Surgical History

Please indicate any surgical procedures you have done in the past, including the date, type, and any pertinent details.

☑ **I Have Never Had Any Surgical Procedures Done**

Integrated Spine, Pain & Wellness
DR. ASHU GOYLE

Patient Name: _____

Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

☐ I Have No Significant Family Medical History ☐ I Am Adopted (No Medical History Available)

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No **If so, are you currently pregnant?** ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar School ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☑ Current Alcoholism ☐ Daily Limited Alcohol Use ☐ History of Alcoholism

☐ Never Drink Alcohol ☐ Social Alcohol Use

Tobacco Use: ☐ Current Tobacco User If yes, how many per day _____ ☐ Former Tobacco ☐ Never Used Tobacco

User **Prescribed Medical Marijuana:** ☐ Yes ☐ No

Drug Use: ☐ Denies Any illegal Drug Use ☐ Currently Using Illegal Drugs (Which _____)

☐ Currently Using Someone Else's Prescription Medications

☐ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotics or prescription medications? ☐ Yes ☐ No (Which: _____)
Have you ever been discharged (fired) from a pain management practice in the past? ☐ Yes ☐ No
If so, please explain here: _____

Fall Risk Assessment for patients 65 and older:

1. Have you had any falls or near falls in past year? ☐ Yes ☐ No

2. If yes, how many? ☐ 1 without injury ☐ 1 with injury ☐ 2 or more (w/o injury)

3. Are you unsteady walking or request assistances? ☐ Yes ☐ No

4. Do you use any assistive device (i.e., cane, walker)? ☐ Yes ☐ No

5. Are you often confused or disoriented? ☐ Yes ☐ No

For staff use: ** If the answer to number 2 is anything but "1 fall without injury", or there is a "yes" for questions 3-5, the patient is at risk for falls and needs a plan of care implemented. **

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Patient Name: _____

Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, on previous page.

Constitutional:
- ☐Chills
- ☐Fevers
- ☐Unexplained Weight Gain
- ☐Difficulty Sleeping
- ☐Insomnia
- ☐Unexplained Weight Loss
- ☐Fatigue
- ☐Low Sex Drive
- ☐Weakness

Eyes:
- ☐Blurry/Double Vision
- ☐Eye Pain
- ☐Eye Redness
- ☐Vision Changes
- ☐Glasses or Contacts

Ears/Nose/Throat/Neck:
- ☐Nosebleeds
- ☐Sinus Problems
- ☐Snoring
- ☐Dental Problems
- ☐Dry mouth
- ☐Bleeding gums
- ☐Earaches
- ☐Hearing Problems
- ☐Ringing in the Ears
- ☐Hoarseness
- ☐Recurrent Sore Throat

Respiratory:
- ☐Coughing Blood
- ☐Sputum Production
- ☐Shortness of Breath at Rest
- ☐Wheezing
- ☐Shortness of Breath upon Exertion

Cardiovascular:
- ☐Chest Pain
- ☐Shortness of Breath while Sleeping
- ☐Light-headedness
- ☐Swelling of Legs
- ☐Palpitations
- ☐Murmur

Gastrointestinal:
- ☐Changes in Appetite
- ☐Diarrhea
- ☐Vomiting
- ☐Changes in Bowel Habits
- ☐Heartburn
- ☐Swallowing problem
- ☐Constipation
- ☐Nausea
- ☐Laxative use
- ☐Antacid Use

Musculoskeletal:
- ☐Back Pain
- ☐Muscle Spasms
- ☐Trauma
- ☐Joint Pain
- ☐Neck Pain
- ☐Joint Swelling
- ☐Stiffness
- ☐Joint stiffness
- ☐Muscle Stiffness

Psychiatric:
- ☐Depressed Mood
- ☐Disturbing thoughts
- ☐Feeling Anxious
- ☐Mood changes
- ☐Stress Problems
- ☐Hallucinations

Skin:
- ☐Dryness
- ☐Lumps
- ☐Hair Texture Change
- ☐Nail Texture Change
- ☐Itching
- ☐Rashes

Neurological:
- ☐Dizziness
- ☐Instability when walking
- ☐Seizures
- ☐Weakness
- ☐Fainting
- ☐Memory Loss
- ☐Tingling
- ☐Stroke
- ☐Headaches
- ☐Numbness
- ☐Tremors
- ☐Loss of Consciousness

Endocrine:
- ☐Cold intolerance
- ☐Heat intolerance
- ☐Excessive Sweating
- ☐Excessive Urination
- ☐Excessive Thirst

Heme:
- ☐Bleeding Easily
- ☐Blood Clots

Genitourinary:
- ☐Blood in Urine
- ☐Painful Urination

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk if you have any questions or are unsure how to complete any section of this form.

Patient Information

Today's Date: _____

Patient's Name: _____ Social Security Number: _____

Date of Birth: _____ Age:_____ Gender: ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip:_____

Email: _____

Physical Address Same as Mailing? Yes ☐ No ☐

If not, please list mailing address:

Occupation: _____ City: _____

Preferred Phone: _____ ☐Home ☐Mobile ☐Work

Secondary Phone: _____ ☐Home ☐Mobile ☐Work

Email: _____ Driver's License # _____ State:_____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☑Other:

Primary Language: ☐English ☐Spanish ☐Other: _____

Referral

Were you referred to our clinic by another physician? If so, whom? _____

If not, how did you hear about us? TV, Radio, Insurance, Family, Friend (if so, whom), Social Media?

_____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City: _____ State:_____ Zip:_____

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Integrated Spine, Pain and Wellness and its providers and staff to treat my condition, and to refer me to other providers if warranted. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Integrated Spine, Pain and Wellness to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Integrated Spine, Pain and Wellness Notice of Privacy Practices and Patient Rights and Responsibility ("NPP"), which is displayed for public inspection at its facility and on its website. That NPP describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Integrated Spine, Pain and Wellness to release my Protected Health Information (medical records) in accordance with its NPP. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Integrated Spine, Pain and Wellness to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Integrated Spine, Pain and Wellness will not release my Protected Health Information to any other party (including family) without my completing an Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** (Please note that Integrated Spine, Pain and Wellness does not have an in-house laboratory and all samples are sent to outside laboratories who generate their own records and billings for their services, separate and apart from Integrated Spine, Pain and Wellness).

I understand that I have the right to refuse specific tests but understand this may impact my pain management treatment. This Consent can be revoked by me at any time with written notification and is valid until revoked.

Signed: _____ Date: _____

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Financial Policy

Integrated Spine, Pain and Wellness believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT -** is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment Integrated Spine, Pain and Wellness reserve the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). If a prepayment is made for any services and a refund is due after insurance processes, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co- insurance, co- payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. I**NSURANCE -** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our providers are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim is rejected for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Integrated Spine, Pain and Wellness only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case, the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **TOXICOLOGY LAB -** In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.

4. **COLLECTION -** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Integrated Spine, Pain and Wellness reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Integrated Spine, Pain and Wellness for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account, including wireless

telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

5. **RETURNED CHECKS -** will incur a $35.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

6. **ACCOUNTING PRINCIPALS -** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. **FORMS AND CONSULTS FEES -** Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the provider. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

8. **CANCELLATIONS OR MISSED APPOINTMENTS -** If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $50.00 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you may be assessed a $100.00 missed procedure fee. Multiple missed visits may result in discharge from the practice.

9. **RESPONSIBILITY FOR PAYMENT -** I understand that I, personally, am financially responsible to Integrated Spine, Pain and Wellness for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS -** I hereby assign, transfer, and set over directly to Integrated Spine, Pain and Wellness sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Integrated Spine, Pain and Wellness to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Integrated Spine, Pain and Wellness. I authorize Integrated Spine, Pain and Wellness to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **RELEASE OF INFORMATION -** I hereby authorize the and direct Integrated Spine, Pain and Wellness to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy of Integrated Spine, Pain and Wellness and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Integrated Spine, Pain and Wellness. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Integrated Spine, Pain and Wellness. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

_____
Patient's Printed Name

_____
Patient's Signature

_____
Guarantor's Signature, if applicable

Date:_____

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Your Name: _____ Date of Birth: _____

Authorized Parties

By signing below, I authorize Integrated Spine, Pain and Wellness, its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party	Relationship

Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient or Legal Guardian

Date

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Authorized Parties

I acknowledge that I have had the opportunity to review Integrated Spine, Pain and Wellness Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Integrated Spine, Pain and Wellness. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

Privacy Officer
Integrated Spine, Pain and Wellness
7425 E Shea Blvd. Ste. 102
Scottsdale, AZ 85260

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

Signature

_____ _____

Signature of Patient or Legal Guardian | Today's Date

_____

Relationship to Patient

Elevate Your Wellness: Know Your Antioxidant Number Now!

Your health is our foremost priority here at ISPW, and we're all about being proactive, not reactive. Ever heard of antioxidants? Think of them as your body's personal security team. They fight off harmful substances that can damage your cells, leading to a whole host of health problems.

Why should you care about your antioxidant levels?

- Antioxidants defend against cell-damaging free radicals, protecting you from a myriad of health issues.
- They keep your immune system robust so you can combat illness effectively.
- They improve your body's ability to heal itself, making recovery from injuries and surgeries quicker and smoother.
-

Here's what our screening could mean for you:

- Enhance Nerve Function and Circulation
- Mitigate Inflammation and Oxidative Stress
- Elevate Sexual Wellbeing
- Expedite Bodily Repair and Regeneration
- Augment Efficacy of Other Recommended Therapies
- Counteract Prescription-Induced Constipation
- Reduce Cancer Risks
- Mitigate the Effects of Aging
- Limit Diabetic Complications
- Fortify Immune Response
- Optimize Cognitive Health and Alzheimer's Risk
- Guard Against Cardiovascular Issues
- Strengthen Bone Integrity
- Alleviate Autoimmune Exacerbations
- Protect Ocular Health
- Promote Skin, Hair, and Nail Vitality

We've incorporated a cutting-edge antioxidant screening technology into our practice. This quick, non-invasive 90-second scan will give us crucial information about your antioxidant levels, helping us tailor a health plan that's right for you. Just place your hand on our state-of-the-art scanner, and you'll get immediate results that I will personally go over with you.

To participate in this invaluable screening, please inform our nursing staff during your visit.

Your Dedicated Health Advocate, Dr. Goyle

Scan this QR code to watch a short video prior to visit

SCAN PHONE CAMERA

If you do not wish to have this evaluation done, please advise the office staff. To cover our cost, you will see a $30 fee added to your office visit for the antioxidant screening. Screenings are not covered by your insurance.

Sign if you wish to receive the scan

Patient Signature: _____ *Date:* _____