



DR. ASHU GOYLE

HOLISTIC PAIN DOC™

7425 East Shea Blvd. Suite 102. Scottsdale, AZ 85260
480-660-8823 www.ispwscoottsdale.com

Welcome!

This intake form is designed to help us understand your needs quickly and clearly. Your answers will guide us in creating a personalized plan that supports healing, movement, and long-term wellness.

Please complete this form before your visit. Total time: ~7 minutes. Thank you for trusting us with your care. Let's get started.

PATIENT DEMOGRAPHICS

Full Name: _____

Preferred Name: _____

Date of Birth: _____ Gender: _____

Phone Number: _____

Email Address: _____

Home Address: _____

EMERGENCY CONTACT

Name: _____

Phone Number: _____

Relationship to Patient: _____

PREFERRED PHARMACY

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

STEP 1: Why You're Here (Core Essentials)

1. What brings you in today? (Body area, symptoms, how long, recent injuries)

2. What are your goals for care? (*Check all that apply*)

- Pain Relief
- Improved Mobility
- Injury Recovery
- Avoid Surgery
- Peak Performance
- Longevity / Joint Preservation
- Wellness / Lifestyle Support
- Other: _____

3. What have you tried so far? (*Check all that apply*)

- Physical Therapy
- Chiropractic
- Acupuncture
- Medications
- Injections
- Surgery
- Other: _____

4. What helped?

5. What didn't help?

6. On a scale of 1 – 10, how would you rate your current pain level?
(1 = Minimal Pain, 10 = Worst Pain Imaginable) _____

STEP 2: How Pain is Impacting You

6. What's currently limited by your pain or condition? *(Check all that apply)*

- Sleep
- Workouts / Movement
- Travel
- Daily Activities
- Mood / Energy
- Other: _____

7. What makes it worse?

8. What makes it better?

STEP 3: Past Testing + Diagnostics

9. Have you had any of the following? *(Check all that apply)*

- MRI
- X-Ray
- CT Scan
- EMG
- Other: _____

(Please upload or bring reports to your visit.)

STEP 4: Medical Snapshot

10. Medical Conditions: *(Check all that apply)*

- High Blood Pressure
- Diabetes
- Arthritis
- Autoimmune Disease
- High Cholesterol
- Cancer (type: _____)
- Other: _____

11. Surgical History (type & year):

12. Current Medications (name & dose):

13. Medication Allergies:

14. Supplements (if any):

STEP 5: Wellness Snapshot

15. What's your profession or daily role?

16. What activities or hobbies do you enjoy?

17. What helps you manage stress or relax?

18. How would you rate your sleep? (Check all that apply)

Excellent

Good

Fair

Poor Avg hrs/night: _____

Do you wake rested? Yes No

Tools used:

Sleep Aids Screens at Night Meditation Sleep Trackers

Other: _____

19. How would you describe your current eating habits? (Check all that apply)

Anti-inflammatory

High Protein

Plant-based

Keto / Paleo

Standard American

Other: _____

Typical eating day: _____

20. Alcohol Consumption:

None

Occasionally

Socially (1-2 drinks/week)

Regularly (3+ drinks/week)

21. Tobacco / Nicotine Use:

Never

Former

Current (type/amount: _____)



Integrated Spine, Pain & Wellness

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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:	<input type="checkbox"/> Chills <input type="checkbox"/> Fevers <input type="checkbox"/> Unexplained Weight Gain	<input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Insomnia <input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> Fatigue <input type="checkbox"/> Low Sex Drive <input type="checkbox"/> Weakness
Eyes:	<input type="checkbox"/> Blurry/Double Vision <input type="checkbox"/> Eye Pain	<input type="checkbox"/> Eye Redness <input type="checkbox"/> Vision Changes	<input type="checkbox"/> Glasses or Contacts
Ears/Nose/Throat/Neck:	<input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Snoring	<input type="checkbox"/> Dental Problems <input type="checkbox"/> Dry mouth <input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Earaches <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> Hoarseness <input type="checkbox"/> Recurrent Sore Throat
Respiratory:	<input type="checkbox"/> Coughing Blood <input type="checkbox"/> Sputum Production	<input type="checkbox"/> Shortness of Breath at Rest <input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of Breath upon Exertion
Cardiovascular:	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath while Sleeping	<input type="checkbox"/> Light-headedness <input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Palpitations <input type="checkbox"/> Murmur
Gastrointestinal:	<input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting	<input type="checkbox"/> Changes in Bowel Habits <input type="checkbox"/> Heartburn <input type="checkbox"/> Swallowing problem	<input type="checkbox"/> Constipation <input type="checkbox"/> Nausea <input type="checkbox"/> Laxative use <input type="checkbox"/> Antacid Use
Musculoskeletal:	<input type="checkbox"/> Back Pain <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Trauma	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Neck Pain	<input type="checkbox"/> Joint Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Muscle Stiffness
Psychiatric:	<input type="checkbox"/> Depressed Mood <input type="checkbox"/> Disturbing thoughts	<input type="checkbox"/> Feeling Anxious <input type="checkbox"/> Mood changes	<input type="checkbox"/> Stress Problems <input type="checkbox"/> Hallucinations
Skin:	<input type="checkbox"/> Dryness <input type="checkbox"/> Lumps	<input type="checkbox"/> Hair Texture Change <input type="checkbox"/> Nail Texture Change	<input type="checkbox"/> Itching <input type="checkbox"/> Rashes
Neurological:	<input type="checkbox"/> Dizziness <input type="checkbox"/> Instability when walking <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness	<input type="checkbox"/> Fainting <input type="checkbox"/> Memory Loss <input type="checkbox"/> Tingling <input type="checkbox"/> Stroke	<input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Loss of Consciousness
Endocrine:	<input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Excessive Urination <input type="checkbox"/> Excessive Thirst
Heme:	<input type="checkbox"/> Bleeding Easily <input type="checkbox"/> Blood Clots		
Genitourinary:	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful Urination		

STEP 6: Referrals and Logistics

22. How did you hear about us?

23. Primary Care Provider:

Name: _____

Phone / Contact Info: _____

24. Referring Specialist (if any):

Name: _____

Phone / Contact Info: _____

25. Anything else you'd like us to know? (Optional)



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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. INSURANCE -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, selfinsured 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



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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 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

– 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



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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

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 of Patient or Legal Guardian

Today's Date

Relationship to Patient