International Center for Health and Wellness, LLC
VCS Testing

Chronic Inflammatory Response Syndrome (CIRS) is a well-established, published, documented condition affecting millions of patients in the US alone. According to the Consensus Statement released November, 2015 by the Center for Research on Biotoxin Associated Illness, "Evidence supports a cause-effect relationship between exposure to the air and dust in **water-damaged buildings (WDBs)** and a chronic inflammatory response syndrome (CIRS) that is linked to certain HLA haplotypes. CIRS-WDB is mediated by an over- reactive innate immune response to the toxins, antigens, and inflammagens found in the interior environment of WDBs." Other causes of CIRS include Chronic Lyme Disease, Brown Recluse Spider Bites, Ciguatera Fish Poisoning, Pfisteria and other Cyanobacteria outbreaks. By far the most common cause is toxic mold and bacteria in a WDB.

24 % of the US population has the genetic susceptibility to **toxic molds and bacteria** from WDB's and **20%** has susceptibility to Borrelia (Lyme Disease). If exposed to these organisms, these patients have no effective innate immune response to identify and eliminate them. The result is chronic immune system inflammation and multiple brain and hormonal abnormalities. According to NIOSH, **50%** of the buildings in the US are WDB's. This may be up to 75% in SW Florida since **Hurricane Ian.** According to the CDC, 300,000 new cases of Lyme Disease were reported last year. Thus, there are a lot of potential patients with CIRS.

The **symptoms** of **Biotoxin Illness/CIRS** appear similar to other common conditions, including Fibromyalgia, Chronic Fatigue and Immune Dysfunction Syndrome (now called Systemic Exertion Intolerance Disease), Autoimmune disorders, Neuropsychological disorders, and Leaky Gut Syndrome. Chronic pain is a common complaint among patients, which can be diffuse, such as in Fibromyalgia, or localized, such as in Myofascial Pain Syndrome and Leaky Gut Syndrome. Fatigue can be severe and debilitating. Sleep disorders, brain fog, headaches and strange neurological symptoms are common.

A screening test for CIRS exists. It is called **Visual Contrast Sensitivity (VCS)** testing. It is based on the fact that Biotoxins, such as toxic mold and bacteria, secrete a neurotoxin that affects the brain and retinal artery blood flow. This interferes with the ability to discriminate white and gray (contrast). While the VCS test was developed by the US military for jet pilots, it has been found to be useful in identifying CIRS patients. If the symptoms are present (multiple organ systems and multiple symptoms) and the VCS test is positive, even in one eye, there is a **98.5%** chance of having CIRS. This makes it one of the most accurate screening tests in medicine. **8%** of patients can be false negative, meaning they have the symptoms, but can pass the test. These tend to be younger people with an eye for details, like graphic designers, artists, baseball and tennis players.

To take the VCS test, go to **https://ichw.vcstest.com** and register as a new user. You will be asked for a donation of **$15.00** and should do that or they will not email the completed results to us.

When taking the test, **follow the instructions exactly**. You must have **good lighting** and your eyes must be **measured** from the screen as told. If you have glasses you wear for working on the computer or reading, use them. You must have **20/50 vision** or better for the test to be accurate. Don't make up or guess the answers to what you are shown; simply identify the direction the lines are going. If you can't see it, just say so. You will do each eye separately. You will be given a score by the website and a determination of the likelihood of Biotoxins present. The results we receive will give more detail and will be reviewed with you on your next visit.

Rev 2/23

INTERNATIONAL CENTER FOR HEALTH AND WELLNESS, LLC.
Alan W. Gruning, D.O.

PATIENT REGISTRATION FORM

Name: _____
(Last) (First) (MI)

Address: _____

City/State/Zip: _____

Home Phone: (___)_____ Cell: (___)_____

Date of Birth: _____ Sex (circle): M F

Employed by: _____ Work Phone: (___)_____

Driver's License #: _____ Email:_____

Northern Address (if applicable): _____

City/State/Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Separated

Spouse's Full Name: _____ Date of Birth: _____

Spouse Employed by: _____ Work phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone#: _____

Referred by: _____

Primary Doctor: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Number: _____

I understand that payment is due at time of service.

Signature: _____

INTERNATIONAL CENTER FOR HEALTH AND WELLNESS, LLC.
Alan W. Gruning, D.O.

NEW PATIENT HISTORY

Name: _____ Age: ___ Date of Birth: _____

Social Security # or the last 4 digits: _____ Sex: □ M □ F Dominant Hand : □ R □ L

Why are you here today? _____

_____

_____

Preventative Health: Please indicate the approximate date you last had the following:

Pap Smear _____ Colonoscopy _____ Chest X-Ray _____

Mammogram _____ Tetanus Injection _____ EKG _____

Bone Density _____ Recent Labs _____ Eye Exam _____

Prostate Exam _____ PSA _____

Do you wear: □ Glasses □ Contacts □ Hearing Aids

Do you wear a brace or orthotic? □ Yes □ No Type: _____

Work Status: □ Employed Type of work: _____

□ Unemployed □ Retired □ At home caregiver

Exercise: □ Yes □ No If yes, what type of exercise: _____

How often? _____ Duration: _____

Do you follow any special diet? □ Yes (please specify): _____
□ No

Do you take calcium? □ Yes □ No If yes, how much daily? _____

List any other dietary supplements: _____

_____

_____

_____

International Center for Health and Wellness, LLC

Alan W. Gruning, D.O.

PAST MEDICAL HISTORY

(Check all that apply)

Patient Name: _____

- □ Brain Injury
- □ Hearing loss; ear: R L
- □ Dental Infections
- □ Low thyroid
- □ Diabetes, pills
- □ Asthma
- □ Rheumatic Fever
- □ High cholesterol
- □ Peptic ulcer disease
- □ Reflux (heartburn)
- □ Diverticulitis
- □ Colon polyps
- □ Kidney infection
- □ TIA
- □ Migraines
- □ Chemotherapy
- □ Sciatica
- □ Depression
- □ Chronic sleep disorder
- □ Other Illness: _____
- □ Visual Loss; Eye: R L
- □ Sinusitis, chronic
- □ Frequent throat infections
- □ High Thyroid
- □ Pneumonia
- □ COPD/emphysema
- □ Heart attack
- □ Angina
- □ Hiatal hernia
- □ Gall bladder disease
- □ Irritable Bowel
- □ Hemorrhoids
- □ Sexually transmitted disease
- □ Seizures
- □ Vertigo
- □ Radiation
- □ HIV
- □ Anxiety disorder
- □ Fibromyalgia
- □ Cataracts; eye: R L
- □ Allergies; nasal/sinus
- □ Thyroid goiter
- □ Diabetes, Insulin
- □ Collapsed lung: R L
- □ Tuberculosis
- □ High Blood Pressure
- □ Valve disease type: _____
- □ Rhythm problems, type: _____
- □ Pancreatitis
- □ Hepatitis, type: _____
- □ Kidney stones
- □ Stroke
- □ Paralysis, location: _____
- □ Cancer, location: _____
- □ Blood disorder, type: _____
- □ Transfusion, year: _____
- □ Other psych. Disorder: _____
- □ Chronic pain, location: _____
- □ Disk injury, location: _____

List all **MEDICATIONS** you are taking: _____

_____

_____

_____

_____

_____

List all **ALLERGIES**: _____

_____

Obstetrical History: __# pregnancies __# Full Term

__# Premature __# Miscarriages __# Abortions

_____ First day last menstrual period

Past Surgical History – list all operations you have had: _____

_____

_____

_____

_____

_____

Family History – List all illnesses of blood relatives in your family: _____

_____

Social History Single / Married / Divorced / Other

Are you being physically, emotionally, or sexually abused: Y / N
Florida Hotline 800-500-1119, A.C.T. 239-939-3112
C.A.R.E. 941-627-6000

Tobacco Use: Y / N # years: _____

□Smoke, packs per day ___ □Chew, amount ____

Alcohol Use: Y / N Rare / Weekly / Daily

Type: _____ Amount: _____

Drug Use: Y / N Type: _____ Amount: _____

Education (highest completed): High School College

Vocational/Technical Graduate School Professional Degree

Spiritual: Do you attend religious services? Y / N

If yes, how often? _____

Where do you attend? _____

Do you pray? Y / N If yes, How frequently? _____

How important is religion to you? Not very / Somewhat / Very

International Center for Health and Wellness, LLC

Alan W. Gruning, D.O.

REVIEW OF SYMPTOMS:

(check all that apply)

Are you currently having any of the following symptoms?

- □Fever
- □Abnormal Sweats
- □Changing Vision
- □Difficulty speaking/swallowing
- □Chest / Arm / Jaw Pain
- □Short of Breath at night
- □Calf pain while walking
- □Sputum production
- □Abdominal pain
- □Loose Stools
- □Constipation
- □Burning w/urination
- □Genital lesions
- □Joint swelling
- □Neck pain
- □Masses under skin
- □Breast problems
- □Numbness/tingling in arms or legs
- □Headache
- □Anxiety
- □Hallucinations
- □Poor Appetite
- □Intolerance to heat
- □Bleeding easily
- □Chills
- □Generalized Weakness
- □Loss of Consciousness
- □Mouth Sores
- □Palpitations
- □Short of Breath w/activity
- □Cough
- □Bloody or rust-colored sputum
- □Acid indigestion
- □Black or tarry stools
- □Yellow skin or eyes
- □Retention/hesitancy of urine
- □Incontinence of urine
- □Warmth in joints
- □Rash
- □Infections in skin
- □General or focal weakness
- □Involuntary movements
- □Tremors
- □Depression
- □Hearing voices that aren't there
- □Severe Thirst
- □Easy Bruising
- □Weight Loss
- □Visual Loss
- □Hearing loss or changes
- □Sinus / Nasal Congestion
- □Short of breath when lying flat
- □Swollen ankles
- □Chest pain w/deep breath
- □Wheezing
- □Nausea / vomiting
- □Vomiting blood
- □Urinary frequency
- □Vaginal / penile discharge
- □Pain in joints
- □Back pain
- □Lesions of skin
- □Itching
- □Change in mentation (thinking)
- □Ataxia or loss of balance
- □Dizziness
- □Suicidal thoughts
- □Insomnia / sleep disorder
- □Intolerance to cold
- □Swollen Lymph Nodes

SPIRITUAL NEEDS

Do you have any spiritual needs that you would like addressed? Yes / No _____

_____

Do you have any prayer requests? Yes / No _____

_____

_____

X_____ _____

Signature: Patient or Legal Guardian Date

Please Print Name: _____

International Center for Health and Wellness, LLC

(Epworth Sleepiness Scale ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0-3)**
Sitting and reading	**0 1 2 3**
Watching television	**0 1 2 3**
Sitting inactive in a public place—for example, a theater or meeting	**0 1 2 3**
As a passenger in a car for an hour without a break	**0 1 2 3**
Lying down to rest in the afternoon	**0 1 2 3**
Sitting and talking to someone	**0 1 2 3**
Sitting quietly after lunch (when you've had no alcohol)	**0 1 2 3**
In a car, while stopped in traffic	**0 1 2 3**
	Total Score:

Patient Name – Printed

Date

International Center for Health and Wellness, LLC

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and cirde a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question,

FSS Questionnaire

During the past week, 1 have found that:	**Disagre ■»- Agree**
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 7
2. Exercise brings on my fatigue.	1 2 3 4 5 6 7
3.1 am easily fatigued.	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 7
7. Fatigue interferes with carrying out certain duties and res;	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 7
	Total Score:

VISUAL ANALOGUE FATIGUE SCALE (VAFS)

Please mark an "X" on the number line which describes your global fatigue with 0 being worst and 10 being normal.

0	1	2	3	4	5	6	7	8	9	10

Patient Name – Printed

Date

PATIENT QUESTIONNAIRE

Updated for DSM-IV™

NAME: _____ **AGE:** _____

SEX: ☐ Male ☐ Female **TODAY'S DATE:** _____

INSTRUCTIONS: This questionnaire will help in understanding problems that you may have. It may be necessary to ask you more questions about some of these items. Please make sure to check a box for every item.

*During the **PAST MONTH**, have you been bothered **A LOT** by...*

	Yes	No
1. stomach pain	☐	☐
2. back pain	☐	☐
3. pain in your arms, legs, or joints (knees, hips, etc)	☐	☐
4. menstrual pain or problems	☐	☐
5. pain or problems during sexual intercourse	☐	☐
6. headaches	☐	☐
7. chest pain	☐	☐
8. dizziness	☐	☐
9. fainting spells	☐	☐
10. feeling your heart pound or race	☐	☐
11. shortness of breath	☐	☐
12. constipation, loose bowels, or diarrhea	☐	☐
13. nausea, gas, or indigestion	☐	☐
14. feeling tired or having low energy	☐	☐
15. trouble sleeping	☐	☐
16. your eating being out of control	☐	☐
17. little interest or pleasure in doing things	☐	☐
18. feeling down, depressed, or hopeless	☐	☐
19. "nerves" or feeling anxious or on edge	☐	☐
20. worrying about a lot of different things	☐	☐

*During the **PAST MONTH**...*

	Yes	No
21. have you had an anxiety attack (suddenly feeling fear or panic)	☐	☐
22. have you thought you should cut down on your drinking of alcohol	☐	☐
23. has anyone complained about your drinking	☐	☐
24. have you felt guilty or upset about your drinking	☐	☐
25. was there ever a single day in which you had five or more drinks of beer, wine, or liquor	☐	☐

Overall, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Printed in USA/April 1995

International Center for Health and Wellness, LLC
Biotoxin Symptom Questionaire

Please check **each** symptom you are experiencing:

____Fatigue

____Weakness
____Decreased ability to retain new knowledge
____Muscle aches
____Headaches
____Light sensitivity

____Impaired memory
____Decreased ability to find words

____Difficulty concentrating

____Joint pains
____Morning stiffness
____Muscle cramps

____Unusual skin sensitivity
____Tingling

____Shortness of breath
____Sinus congestion

____Cough
____Excessive thirst
____Confusion

____Appetite swings
____Difficulty regulating body temperature
____Increased urinary frequency

____Red eyes
____Blurry vision
____Night sweats
____Mood swings
____Ice-pick pains

____Abdominal pain
____Diarrhea
____Numbness

____Static shocks
____Vertigo (Dizziness)

____Tearing of eyes
____Disorientation
____Metallic taste

_____ _____

Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ 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

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.	
Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ Not Much ◯ Some ◯ A Lot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

Patient Name: _____ Date: _____

International Center for Health and Wellness, LLC.

Mailing Address:
6900 Daniels Parkway
Suite 29 PMB 173
Fort Myers, FL 33912

Phone: 239-939-3303

Consent for Email Communication

I understand that there are security risks associated with sending Patient Health Information in emails. Although the email server for ICHW is encrypted and secure, I acknowledge that my personal email server and/or electronic device(s) may not be secure, and that is my responsibility. This lack of security in emails applies to any other unencrypted email that I give consent to use for communication.

If I choose email communication, I understand that there is a pass code required to access any email that is sent. This will be the last four digits of my social security number and must be on file prior to ICHW sending any emails. I understand that emails will be automatically deleted within 28 days from the recipients' email server. I have the option to download and save my emails.

I give consent for the following types of emails:
___ to myself at the following email address _____
___ to my attorney regarding my case. My attorney's name is _____
_____
___ to my auto insurance company which is _____

This authorization is for:
___ one time use for
___lab results ___radiology report ___other _____
___ all future use until I revoke this authorization in writing. I must sign a new form if I retain/change an attorney or wish to use a new email.

_____
Patient Printed Name

_____ _____
Patient Signature Date

INFORMED CONSENT FOR **TELEMEDICINE SERVICES** DURING COVID-19 PANDEMIC

Patient Name:	
Date of Birth:	Medical Record #:
Physician Name:	Date Consent Discussed:
Location:	

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

All efforts will be made to utilize electronic systems with network and software security protocols to protect the privacy and security of health information and to safeguard the data against corruption. However, in order to ensure greater access to care while limiting the spread of COVID-19, the mode of communication used during your telehealth consultation may not be secure and may be subject to privacy risks.

Anticipated Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides care from a distant site
- Limiting the spread of COVID-19
- More efficient medical evaluation and management
- Ability to obtain consultation of a distant specialist
- Conservation of personal protective equipment such as gloves and masks to reduce shortages for healthcare providers

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, it may be determined that the information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation/treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By Signing this Form, I Understand the Following:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed to researchers or other entities without my authorization.
3. I understand that during the COVID-19 Pandemic, security measures may be lessened in accordance with U.S. Department of Health and Human Services (HHS) to ensure improved access to care.
4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment.
5. I understand there may be technological challenges that prevent recording the telemedicine interaction during the COVID-19 pandemic, but that I have the right to inspect all information obtained and successfully recorded and may receive copies of this information for a reasonable fee.
6. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.

7. I understand that the telemedicine visit may occur with a licensed medical provider who is not licensed in my state of residence. I also understand there may be electronic communication of my personal medical information to other medical providers who may be located in other states.

8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

9. I understand that certain fees for service may be waived during the COVID-19 Pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I may be responsible for any copayments or coinsurances that apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost, I will be responsible for payment.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine during the COVID-19 Pandemic. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

I hereby **authorize** _____ (name of physician) to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Signature of Patient
(or person authorized to sign for patient):

Date

_____

If authorized signer,
Relationship to patient:

_____ _____

Witness

Date

I hereby **refuse** _____ (name of physician) to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Signature of Patient
(or person authorized to sign for patient):

Date

_____

If authorized signer,
Relationship to patient:

_____ _____

Witness

Date

I have been offered a copy of this consent form (patient's initials) _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

International Center for Health and Wellness, LLC.

I am a patient of International Center for Health and Wellness, LLC. I hereby acknowledge receipt of International Center for Health and Wellness, LLC. 's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of International Center for Health and Wellness, LLC. 's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: _____ Parent _____ Legal Guardian

Signature: _____

Date: _____

International Center for Health and Wellness, LLC
6900 Daniels Parkway
Suite 29 PMB 173
Fort Myers, FL 33912

Phone: 239-939-3303 **FAX: 866-677-0504**

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SS#: _____

By signing this authorization, I authorize: _____
(Name of Hospital/Physician)
to use and/or disclose certain protected health information (PHI) about me for the purpose of Medical Treatment to:

☐ **International Center for Health and Wellness, LLC** ☐ **Self** ☐ **Other**: _____

Information to disclose:

☐ Emergency department records, any X-Ray, MRI, Cat Scans, Lab Test, Physician Reports, Patient Demographics

☐ Complete Records

☐ Other: _____

This authorization will expire on _____

I do not have to sign this authorization in order to receive treatment from International Center for Health & Wellness, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used and 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 HIPAA Privacy Rule. 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 at:

International Center for Health and Wellness, LLC
6900 Daniels Parkway
Suite 29 PMB 173
Fort Myers, FL 33912

The Practice WILL NOT receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

_____ _____
Patient Signature or Legal Guardian: Date

_____ _____
Print Name of Patient Relationship to Patient

If this FAX is not received in its entirety please contact our office.

International Center for Health and Wellness, LLC

6900 Daniels Parkway, Suite 29-173
Fort Myers, Florida 33912
239.939.3303

Consent for Alternative Treatment

I, _____, consent to have Alan W Gruning, DO and all healthcare providers employed by the International Center for Health and Wellness, LLC (ICHW) treat me for my conditions. I have sought treatment from ICHW because I have either failed standard medical treatments for my condition, and continue to be ill, or I desire a more holistic/functional medicine treatment approach for my conditions.

I give ICHW permission to treat me with alternative therapies for my conditions, which include but are not limited to Fibromyalgia, Chronic Fatigue and Immune Dysfunction Syndrome, Autoimmune Disorders, Environmental Toxicity such as Biotoxin Illness (Chronic Inflammatory Response Syndrome), Thyroid and Adrenal Disorders, and Hormone Imbalances. I will become knowledgeable about standard and alternative treatments for my conditions. I understand the treatments that ICHW provides are not guaranteed to cure my condition and may not help me. I do not hold ICHW, Dr. Gruning, and the healthcare providers of ICHW liable for any lack of progress, side effects of treatments, adverse outcomes, or unforeseen problems resulting from my treatment plan.

I consent to be a willing and compliant patient in the ICHW medical practice. I will obtain all requested diagnostic tests in a timely manner. I will adhere to the prescribed treatment plan. I will comply with all required appointments and I will schedule appointments as requested by ICHW.

_____ _____

Patient Signature Date

International Center for Health and Wellness, LLC

Informed Consent for Off-Label Medications

Off-label medications are those approved by the FDA for one purpose, but are being used for another purpose. This is done commonly in the medical community. 20% of all prescriptions are written off-label.

Biotoxin Illness (CIRS) patients are prescribed pure Cholestyramine (CSM) and/or Welchol (colesevelam) as the binder to remove Biotoxins from their bodies. These medications are being used off-label. They are approved for lowering total and LDL cholesterol by the FDA. Their effect as Biotoxin binders have been extensively published in the scientific literature. Other binders are not nearly as effective and have no data to support their use for CIRS patients. Pure CSM is available from certain compounding pharmacies. Welchol is available from any pharmacy.

Direct side effects of CSM and Welchol are minimal and usually relate to GI problems (bloating, constipation). However, additional symptoms may result from an intensification reaction when toxins are removed too rapidly without pre-treatment with omega 3 fatty acids. It is important to follow our instructions precisely as covered in the Biotoxin Treatment Overview that you have been provided. If side effects develop that are not easily managed, please discontinue the medication and report the problems to Dr. Gruning.

Dr. Gruning may prescribe Losartan in certain cases, which is approved for lowering blood pressure. It also has published effectiveness in temporarily lowering the most important Cytokine in CIRS patients, TGF beta-1. No other medication is known to do this. Side effects are mostly related to lowering the blood pressure too much. If side effects occur, please discontinue the medication and notify Dr. Gruning.

I understand the above and consent to use CSM, Welchol, and/or Losartan off label, as prescribed, as part of my treatment regimen.

_____

Printed Name

_____

Signature

_____

Date

International Center for Health and Wellness, LLC
6900 Daniels Parkway, Suite 29-173
Fort Myers, Florida 33912
239.939.3303

Patient Agreement

I, _____, agree to comply with the following in order to be a patient of International Center for Health and Wellness, LLC and Alan Gruning, DO:

1. Due to changes in Telemedicine laws, I will **only** be seen in states that Dr. Gruning is **licensed**.
2. Due to the complexity of caring for patients with Biotoxin Illness/CIRS and other serious conditions, I agree that I will **schedule** a visit to see Dr. Gruning **at least monthly** until he says my visits can be less often. I will be told at each visit when I am expected to return. I will **schedule** my next office visit with the front office staff **prior to leaving** or during the virtual visit follow up call from the staff.
3. I agree to schedule and complete **all recommended testing promptly.**
4. I will **notify** the office of the need for special attention due to an unexpected reaction, side effect, or worsening of my condition. It may take several days to respond to me. If I am having an **emergency**, I will call 911 or proceed to the closest hospital Emergency Department.
5. The office will be open **limited hours** as published on the website and I will leave a voice message or email the staff with any urgent needs I have **during normal business hours**. I understand it may take **5 business days** for a response.
6. **Prescription refill requests** should occur during my office visit. If I am running low on a medication, I understand that refill requests will require up to **5 business days** to be completed, so I will notify the office with plenty of advance notice. I understand that **prescriptions are only refilled for actively treating patients** that are complying with recommended testing and follow up visits.
7. I consent to be contacted by ICHW staff by **text and email**.
8. **Coordination of Care**: I consent for ICHW to coordinate my care with other professionals needed to treat my condition. I also consent to be entered into **Fullscript** and receive texts/emails so that I may order needed supplements and receive a discount.
9. I will treat all employees of ICHW with **respect, courtesy and professionalism**. If I do not, I will be discharged from the medical practice. Rude and abusive behavior **will not** be tolerated.
10. I understand that if Dr. Gruning **recommends another professional** to assist in my care (i.e. Indoor Environmental Professional, HVAC contractor, Remediation specialist), he and this practice have **no** financial relationship with that professional. I am free to choose whoever I want to participate in my care, but I will need to find a professional that is **at least** as qualified and experienced in the care of Biotoxin Illness/CIRS patients as the one recommended.
11. I understand that I need to **pay for services** provided at the time they are rendered by cash or credit card. My fees cover not only Dr. Gruning's time and expertise, but also the office staff time spent with me explaining testing, returning phone calls and email requests, record keeping, and interaction with diagnostic testing facilities. The generation of **letters/reports** may require an additional fee. I may be asked to schedule and pay for a **virtual or phone consultation** if I need extended time to answer my questions or explain test results.
12. Our **physician/APRN visit rates** (in person or virtual) are posted on our website under the FAQ's.

_____ _____

Signature Date

International Center for Health and Wellness, LLC
Alan W Gruning, DO

PLEASE SIGN EITHER UNDER "A" OR "B" BELOW. DO NOT SIGN UNDER BOTH:

A. Declaration Under Penalty of Perjury

I, _____, hereby declare and represent under penalty of perjury that I am NOT a beneficiary enrolled in Medicare Part B, hereinafter called "Beneficiary," and I hereby covenant and agree to abide by all of the terms and conditions of the **Medicare Opt-Out Private Contract** below if I ever become a Beneficiary.

Patient Name (please print):_____

Patient Signature:_____ Date:_____

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or

B. Medicare Opt-Out Private Contract

This agreement is entered into by and between Alan Gruning, DO and the International Center for Health and Wellness, LLC (hereinafter called "Provider"), and _____ (a beneficiary enrolled in Medicare Part B, hereinafter called "Beneficiary").

Background

A change in the Social Security Act, effective January 1, 1998, permits Medicare beneficiaries and providers to contract privately outside the Medicare program. Under the law as it existed prior to January 1, 1998, a provider was not permitted to charge a beneficiary more than a certain percentage in excess of the Medicare fee schedule amount (limiting charge). The law now permits providers and beneficiaries to enter into private arrangements through a written contract under which the Beneficiary may agree to pay the Provider more than that which would be paid under the Medicare program.

However, beneficiaries and providers who take advantage of this provision are not permitted to submit claims for payment or to expect payment for those services from Medicare. The Provider has certain other obligations, such as filing an affidavit with the appropriate Medicare carrier(s). The purpose of this contract is to permit the Beneficiary and the Provider to take advantage of this change in Medicare law, and it sets forth the rights and obligations of each. Furthermore, this agreement is limited to the financial agreement between Provider and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Obligations of Provider

1. Provider agrees to provide such treatment as may be mutually agreed upon by the parties and using fees as listed on our website under the FAQ's.

2. Provider agrees not to submit any claims for payment under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

3. Provider acknowledges that he will not execute this contract at a time when the Beneficiary is facing an emergency or urgent healthcare situation.

4. Provider agrees to provide the beneficiary or his/her legal representative with a copy of this document before items or services are furnished to the beneficiary under its terms.

5. Provider agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS), upon the request of the CMS.

Obligations of Beneficiary

1. Beneficiary or his/her legal representative agrees to be fully responsible for payment of all items or services furnished by Provider and understands that no reimbursement will be provided under the Medicare program for such items or services.

2. Beneficiary or his/her legal representative acknowledges and understands that no limits under the Medicare program (including the limits under section 1848 (g) of the Social Security Act) apply to amounts that may be charged by Provider for such items or services.

3. Beneficiary or his/her legal representative agrees not to submit any claim for payment to Medicare for services rendered by this office and further agrees not to ask Provider to submit a claim for payment to Medicare.

4. Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by Provider that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

5. Beneficiary or his/her legal representative enters into this contract with the knowledge and understanding that he/she has the right to obtain Medicare-covered items and services from providers and practitioners who have not opted out of Medicare, and that the Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other providers or practitioners who have not opted out of Medicare.

6. Beneficiary or his/her legal representative understands that Medigap plans (under section 1882 of the Social Security Act) do not (and other supplemental insurance plans may elect not to) make payments for such items and services not paid for by Medicare.

7. Beneficiary or his/her legal representative acknowledges that the Centers for Medicare and Medicaid Services (CMS) has the right to obtain copies of this contract upon request.

Provider's Status

Beneficiary or his/her legal representative further acknowledges his/her understanding that Provider has not been excluded from participation in the Medicare program under section 1128, 1156, 1892 or any other section of the Social Security Act.

Term and Termination

This agreement shall become effective when signed and shall continue until either: (1) the provider's opt out status is rescinded or canceled; or (2) cancellation is requested by the Beneficiary or his/her legal representative.

Either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Provider and Beneficiary (or his/her legal representative) agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract shall survive this contract.

Successors and Assignees

Provider and Beneficiary (or his/her legal representative) agree that this agreement shall be fully binding on their heirs, successors, and assignees. The parties hereto, intending to be legally bound by signing this agreement below, have caused this agreement to be executed on the date written

below.

Patient Name (please print):_____

Patient Signature:_____ Date:_____

If applicable:
Name of Personal Representative (please print):_____

Signature of Personal Representative:_____Date:
_____
Authority of personal representative to sign for patient (check one):

- _____Parent
- _____Guardian
- _____Power of Attorney
- _____Other:_____

Printed Name of Provider Representative:_____

Title:_____

Provider Representative Signature:_____ Date:
_____