NEW AGE MEDICAL CLINIC PA INTAKE EVALUATION (973) 313-0028

Name: _____ **Date:** _____

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

Cell phone: _____ **Home phone:** _____**Email:** _____

Emergency Contact: Name: _____ **Phone:** _____

HOW DID YOU FIND OUT ABOUT US? ____Internet Search | ____Signs | ___ Car Sign |_____business card | referred by

_____ **Date of Birth: ____/____/____ Gender: M____F____ Marital Status: S____ M____D____W ____**

Age: ____Height____' ____ " | Weight: ____lbs.

ALLERGIES: (please list any foods, drugs, or medications you are hypersensitive or allergic to. Please include reaction.) _____

_____

MEDICATIONS:_____

SUPPLEMENTS:_____

CHRONIC MEDICAL AILMENTS:_____

CURRENT SYMPTOMS OR COMPLAINTS: _____

WHY ARE YOU HERE?_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Please complete all information and indicate areas of confusion with a question mark. Thank You.

Skin Assessment:

Do you have any of the following concerns (check ALL that apply):

Fine lines ____	Dark spots____	Scars (acne or surgical) ____	Under eye circles____
Stretch marks____	Deep wrinkles____	Rough skin texture____	Sagging skin____
Large pores ____	Sagging cheek bones____		

Other (please describe)_____

FEMALES: Is it possible you may be pregnant? : yes____ no____ | If "yes" How far along are you or may you be?

Menstrual/Birthing History

Last Menstrual Cycle:_____

Are you using birth control? : yes____ no____ | (if "yes" What kind?)_____

____Age of first Menses	____# Of Days of Menses	____# of Live Births	____# of Abortions
____# of Pregnancies	____# of Miscarriages	____Length of Cycle	____Birth Control Type _____

When and where did you last receive health care?_____

For what reason?_____

Do you have any infectious diseases? : yes____ no____

If "Yes" Please Identify:_____

Family History (check those that apply)

Mother:

Living: yes____ no____ |(age at death____) (cause of death) _____

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

Mother's Illnesses: Cancer: yes____ no____ | Heart Disease: yes____ no____ | Stroke: yes____ no____ | Diabetes: yes____ no____ | Mental Illness: yes____ no____ | Kidney Disease: yes____ no____ |

Father:

Living: yes____ no____ |(age at death____) (cause of death) _____

Father's Illnesses: Cancer: yes____ no____ | Heart Disease: yes____ no____ | Stroke: yes____ no____ | Diabetes: yes____ no____ | Mental Illness: yes____ no____ | Kidney Disease: yes____ no____ |

Siblings: All Living: yes____ no____ |(age at death(s)) (cause of death_____

Siblings Illnesses: Cancer: yes____ no____ | Heart Disease: yes ____ no____ | Stroke: yes____ no____ | Diabetes: yes____ no____ | Mental Illness: yes____ no____ | Kidney Disease: yes____ no____ |

Your weight for past 10 years: Past Max Weight: Past Min Weight:

Blood Pressure: What is your most recent blood pressure reading? ____ / ____ Taken: ____

Digestion Issues:

Blood in stool____	ABD Pain__	Constipation____	Residual When Wiping____
Diarrhea____	Bloating____	Incomplete Evacuation____	ABD cramping____
Nausea ____	Gas____	Small Round Stool____	Diverticulosis / diverticulitis____
Vomiting____	ABD Distention____	Hard Stool____	Hemorrhoids (internal or external) ____

Other digestive concerns if any (if "yes" describe) :_____

BM FREQUENCY: Number of times Per Day: ____ Per week: ____

Do you have a diet low in fiber: yes____ no____

Does your diet include a lot of meat/cheese or processed foods: yes____ no____

Incontinence: yes____ no____

Painful defecation: yes____ no____

Last Bowel Movement _____

Previous Interventions: ____ None | ____ Laxatives / Enemas

Description of Bowel Movements: Color _____

Consistency: (check all that apply): ____thin | ____ thick | ____ hard | ____ soft| ____ watery| ____ small round| ____ clay like.

Ulcers____	Epigastric Pain____	Belching ____	Hepatitis A, B or C ____
Changes In Appetite____	Passing Gas____	Gallbladder Disease____	Hemorrhoids____

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

Nausea/Vomiting ____	Heartburn____	Liver Disease____	Abdominal Pain____

Any Diagnosis of Cancer or non-malignant tumors: yes____ no____

When Diagnosed: _____ What was exact diagnosis: _____

Who was Doctor: _____ Dr's Phone#: _____

All Treatment(s) received:_____

Currently Cancer FREE? : yes____ no____ | Current Restrictions: yes____ no____ (if yes describe):

Childhood Illness: (check any that you have had):

Scarlet Fever ____	Rheumatic Fever ____	Measles ____	Chicken Pox ____
Diphtheria ____	Mumps ____	German Measles ____	Anything else ____

Describe: _____

Immunizations: (check any that you have had): Polio____ | Tetanus ____ |Rubella/Mumps ____ | Pertussis ____ | Diphtheria____ | HiB ____ | Hepatitis-B ____ | Chicken Pox ____ | Pneumonia ____ | Flu ____ | Other:_____

Hospitalizations and Surgeries: Describe: _____

When and what happened:_____

X-Rays / CAT Scans / MRIs / NMRs / Special Studies:

When and what happened: _____

Emotional/ Psychiatric :

Mood Swings____	Mental Tension____	Depression ____	Obsessive Thinking____
Nervousness____	Irritability____	Grief____	Thoughts hurt self /others____

Describe: _____

Energy and Immunity :

Fatigue____	Slow Wound Healing ____	Chronic Fatigue____
Yeast Infections____	Chronic Infections____	Lyme Disease____

Describe: _____

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

Head, Eye, Ear, Nose, Throat :

Impaired Vision ____	Eye Pain/Strain ____	Glaucoma ____	Glasses/Contacts ____
Tearing/Dryness ____	Impaired Hearing ____	Ear Ringing ____	Earaches ____
Headaches ____	Sinus Problems ____	Nose Bleeds ____	Frequent Sore Throats ____
TMJ/Jaw Problems ____	Hay Fever ____	Runny Nose ____	Balance Issues ____

Describe: _____

Respiratory :

Pneumonia____	Difficulty Breathing ____	Asthma ____
Bronchitis ____	Emphysema ____	Tuberculosis ____
Frequent Common Colds ____	Persistent Cough ____	Shortness of Breath ____

Describe: _____

Cardiovascular :

Heart Disease ____	Palpitations/Fluttering ____	Rheumatic Fever ____	Heart Attack (MI) ____
Chest Pain ____	Stroke ____	Varicose Veins ____	Angina ____
Swelling of Ankles ____	Bruising ____	Abnormal Bleeding ____	Edema ____
High BP ____	Heart Murmurs ____	Pain in Calves ____	Congestive Heart Failure ____

Describe: _____

Genito-Urinary Tract :

Kidney Disease____	Frequent UTI ____	Impaired Urination____	Frequent Night Urination ____
Painful Urination____	Kidney Stones____	Blood in Urine____	Flank Pain ____

Describe: _____

Female Reproductive / Breasts :

Irregular Cycles ____	Vaginal Discharge____	Bleeding Between Cycles ____	Painful Periods ____

X _____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

Breast Lumps/Tenderness____	Premenstrual Problems ____	Menopausal Symptoms____	Painful Intercourse ____
Nipple Discharge ____	Clotting ____	Difficulty Conceiving ____	Vaginal Dryness ____

Male Reproductive : Erectile Dysfunction ____ | Prostrate Issues ____ | Testicular Pain ____ | Penile Discharge ____ | Frequent Urination____ |

Describe: _____

Musculoskeletal : Neck/Shoulder Pain ____ | Muscle Spasms/Cramps____ | Arm Pain ____ | Upper Back Pain ____ | Mid Back Pain ____ | Lower Back Pain ____ | Leg Pain ____ | Joint Pain ____ | Other Pain ____

Describe: _____

Neurologic : Vertigo/Dizziness ____ | Paralysis ____ | Numbness/Tingling ____| Loss of Balance ____ |

Seizures/Epilepsy ____ | Migraines ____ | Stroke ____ | Memory Loss ____ | Weakness on one side of body ____

Describe: _____

Endocrine : Hypothyroid ____ | Hypoglycemia ____ | Hyperthyroid ____ | Diabetes Mellitus ____ | Diabetes Insipidus ____ |

Night Sweats ____ | Feeling Hot or Cold ____ | Abnormal Weight gain ____ | Difficulty Losing Weight ____

Describe: _____

Lifestyle:

a. How many meals per day do you eat? ____
b. Exercise routine: _____
c. Spiritual Practice: _____
d. How many hours per night do you sleep? Do you wake rested? : yes____ no____
e. Level of education completed: | High School ____ | Bachelors ____ | Masters ____ | Doctorate ____| Other (describe): _____
   Occupation: _____Employer: _____ Hours/Week: _____ Do you enjoy work? : yes __ no__
f. Nicotine Use (what form):_____ (past or present)
   Amount:_____ Frequency:_____
g. Alcohol Use (what form): yes____ no____ (if no when was last time you consumed) : Amount:_____ Frequency: _____
h. Recreational Drugs: yes____ no____ (if no when was last time you consumed) :_____Type(s)_____
   Amount: _____ Frequency: _____
i. Have you experienced any major physical traumas? (injuries, surgeries, abuse) : yes____ no____
   Describe: _____
j. How many 8 oz glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Primary Physician:_____ Phone:_____

(If you use Urgent Care Clinic as Primary Care write "Urgent Care" if You us Emergency Department write "ED")

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

ARBITRATION AGREEMENT & PATIENT DISCLOSURE:

I _____(hereafter "PATIENT") certify that I am a BONIFIED Patient of DR. Maria Romanenko, DO/ New Age Medical Clinic PA (hereafter "Medical Clinic")and that any ill intention or action taken by me that creates a financial harm, potential harm to reputation or hinders business practices or fosters the development of a competing medical practice of Medical Clinic shall be deemed detrimental to the business. PATIENT seeks to benefit from the services provided by Medical Clinic seeks to benefit from fees charged to PATIENT.

In the event that it is discovered that PATIENT is not a BONIFIED patient and that PATIENT's motivation for engaging the time, efforts and expertise of the staff of Medical Clinic was to promote a competing business venture or to bring about any action or publicity that might cause financial harm to Medical Clinic its shareholders or employees; PATIENT agrees to be personally liable (even if working on behalf of another party) for all financial costs, opportunity costs, employee hourly fees and legal fees for collection of damages.

Furthermore, PATIENT and Medical Clinic agree that all disputes will be settled by binding arbitration through American Arbitration Association (AAA). However, as necessitated by the fact that delays might occur in obtaining injunctive relief in Arbitration and continued disclosures by PATIENT will irreparably harm the business of Medical Clinic both PATIENT and Medical Clinic agree to the exception that New Jersey Superior Court of Essex, Bergen or Monmouth County (or court of competent jurisdiction) and is hereby authorized by both PATIENT and Medical Clinic to grant injunctive relief (Temporary Restraining Order) without necessity of posting a bond until such time as a board of Arbitration can be convened to decide the case, both parties agree that utilizing American Arbitration Association (AAA) to grand injunctive relief or decide the case will cause irreparable harm to Medical Clinic Additionally, both Patient and Medical Clinic agree that Medical Clinic is permitted at any point to seek any type of provisional/interim relief from American Arbitration Association (AAA); as neither party has chosen to waive the ability of an arbitrator to provide provisional remedies, including interim relief without necessity of posting a bond. Both parties acknowledge the have had ample opportunity to have legal counsel review this agreement and are not being coerced in any way to sign this agreement.

1) Dr. Maria Romanenko, DO/ New Age Medical Clinic PA (hereafter "Medical Clinic") is NOT my primary Medical Doctor;
2) All medical decisions regarding any current or future health conditions should be addressed by my primary care physician;
3) Medical Clinic serves as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness; all acute illnesses will be addressed by primary care physician NOT by Medical Clinic.
4) All medical information supplied by me is accurate and forthcoming;
5) I have informed my primary care physician about services I am to receive at Medical Clinic and he/she has no objections to such services.
6) I have NOT been rushed into making any decisions and I have had ample opportunities to ask Dr. Maria Romanenko, DO and my primary care physician questions prior to receiving any treatment.
7) I acknowledge that Medical Clinic does not provide any promises or guarantees that the treatments I am to received will be effective in helping to improve my current health conditions and that in coming to Medical Clinic I had previously made a decision independent of Medical Clinic to try the services offered at Medical Clinic.
8) I understand that there are NO REFUNDS for any reasons.
9) I am not under any sort of pressure or duress because of a current medical condition and I have not been made any promises as to the results or effectiveness of such services/treatments and have been provided with detailed costs for services and I can afford the services I am requesting without creating a hardship for myself or those depending on me financially.
10) I authorize Medical Clinic to charge my credit card (amex, visa, mastercard or discover) to pay for services.
11) I consent to live encrypted audio & video monitoring (ie: webcam / FaceTime) during intake, IV Vitamin & Nutrient administration, physical exam and instructional sessions to Medical Director or other medical staff as necessary when off site.
12) I authorize use on text / SMS and pre-recorded messages to my cell phone home phone to confirm appointments and inform me of special discounts I am entitled to (I can opt out of such services at any time).

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

NEW AGE MEDICAL CLINIC PA INTAKE EVALUATION (973) 313-0028

IMMEDIATE NEED FOR HEALTH RECORDS I hereby authorize the use or disclosure of my health information as follows:

PRIMARY CARE PHYSICIAN: _____Address: _____

_____(fax) _____

Patient Name: _____ SS# _____

Date of Birth: ____/___/_____

IMMEDIATELY FAX RECORDS TO: **FAX: 973-210-4500**

PLEASE FAX: ALL Diagnosis for current or significant past medical history and laboratory or diagnostic studies for past 12 months

PURPOSE: **Continued Medical Care**

EXPIRATION: **12 Months from date of client signature or when revoked by client**

NOTICE OF RIGHTS AND OTHER INFORMATION
• I may refuse to sign this Authorization.
• I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following: **FAX to 973-210-4500**

• My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
• I have a right to receive a copy of this authorization.
• Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
• Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, New Jersey law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I_____ (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

X_____ (Patient Initial)

HIPAA Privacy Rule of Patient Authorization & Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

• a basis for planning my care and treatment;
• a means of communication among the health professionals who may contribute to my healthcare;
• a source of information for applying my diagnosis and surgical information to my bill;
• a means by which a third-party payer can verify that services billed were actually provided;
• a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

• I have the right to review this facility's Notice of Information practices prior to signing this consent;
• This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
• I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
• I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
• It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

PATIENT HISTORY OF:

migraines	yes	no
congestive heart failure	yes	no
asthma	yes	no
epilepsy	yes	no
kidney disease	yes	no
undiagnosed uterine bleeding	yes	no
heart disease	yes	no
ulcerative colitis	yes	no
Crohn's disease	yes	no
are you nursing	yes	no
hormonal imbalances you are treated for	yes	no
thyroid or adrenal gland disorder	yes	no
bleeding disorders	yes	no
cancer **(or a tumor of the breast, ovary, uterus, prostate, hypothalamus, or pituitary gland)**	yes	no
diabetes	yes	no
brain surgery	yes	no
history of anorexia	yes	no
ovarian cyst	yes	no
do you have a history of bulimia	yes	no
is there any chance you are pregnant	yes	no
cirrhosis of the liver	yes	no
current pregnancy	yes	no
coronary occlusion (heart attack)	yes	no
cerebral vascular accident	yes	no
take diuretics	yes	no
swollen ankles	yes	no
Rheumatic pains	yes	no
menstrual disorders	yes	no
breathlessness on exertion	yes	no
Do you have any major or chronic medical ailments	yes	no
Any existing medical condition not listed on the intake forms	yes	no

EXPLAIN ALL "YES" ANSWERS:

_____

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

Patient Name_____ **COLON HYDROTHERAPY CONSENT**

COLONIC PATIENTS ONLY

NEW AGE MEDICAL CLINIC PA does NOT treat diseases and any services performed by staff, are designed to improve overall wellbeing of our patients.

Patient agrees to consult with primary care physicians as to the safety and efficacy of the treatments provided by staff at NEW AGE MEDICAL CLINIC PA given their familiarity with patient's underlying medical history and response to medications received. Patient has not been pressured to make any decision and I have had the opportunity to discuss all treatments proposed with my primary care physician and given the opportunity to ask questions.

Patient confirm they are making an informed decision based on all the information provided by NEW AGE MEDICAL CLINIC PA and my primary healthcare practioner(s) and I have had the opportunity to review any peer reviewed scientific journals that may have reported on the therapies proposed. Such journals can be reviewed for free at UMDNJ Library 30 12th Ave. Newark NJ, 07101, Phone: 973-972-4580 or accessed by subscribing online at http://www.questia.com

Treatments may have risk factors listed or cause the side effects listed below. However, as these treatments may not have been funded for widespread scientific review under controlled conditions and have not been reported in peer reviewed scientific journals; there may be some side effects that we cannot predict.

- The patient's diagnosis, if known: **constipation** | **bloating** | **heart burn / acid reflux** | **gas** | **abdominal pain** | **bad breath** | **acne** | **(other)**_____
- The nature and purpose of a proposed treatment or procedure: Colonic (Colon Hydrotherapy)
- The benefits of a proposed treatment or procedure: Relief of Constipation, gas, bloating and accumulated fecal material and possible improvement of atrophy of colon muscle.
- Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance): laxatives, increase fiber, change diet
- The risks of not receiving or undergoing a treatment or procedure: stay the same or get worse
- The benefits of not receiving or undergoing a treatment or procedure: save money or condition may resolve itself

Colonics: Side effects / Potential risks or discomfort: abdominal cramping if severely impacted, fluid overload if patient has history of uncontrolled hypertension or heart failure, intestinal perforation if patient has had recent colon surgery or bleeding

DO YOU HAVE or HAVE YOU EVER BEEN DIAGNOSED WITH:

- ***congestive heart failure*** YES / NO
- ***diverticulitis*** (current infection) YES / NO
- ***ulcerative colitis*** YES / NO
- ***Crohn's disease*** YES / NO
- ***severe or internal hemorrhoids*** YES / NO
- ***tumors in the rectum or colon*** YES / NO
- ***intestinal perforation*** YES / NO
- ***carcinoma of the rectum*** YES / NO
- ***fissures or fistula*** YES / NO
- ***painful abdominal hernia*** YES / NO
- ***renal insufficiency*** YES / NO
- ***recent colon or rectal surgery*** YES / NO
- ***cirrhosis of the liver*** YES / NO
- ***first or last trimester of pregnancy*** YES / NO

X_____ _____ X _____ _____

Patient Signature Date Staff Witness Date

I _____ (patient name) acknowledge and understand that DR. Maria Romanenko, DO/ New Age Medical Clinic PA (hereafter "Medical Clinic") is NOT my primary Medical Doctor and ALL medical decisions regarding any current or future health conditions should be addressed by my primary care physician. I have spoken to my primary care physician regarding the services I am seeking and he/she has no objections to my starting B12 Shots & MIC Lipotropic SHOTS. Medical Clinic serves as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness.

I acknowledge that there are no guarantees relating to the effectiveness of the B12 Shots & MIC Lipotropic SHOTS and that I have done my own research and have made a well informed decision to B12 Shots & MIC Lipotropic SHOTS and agree that Medical Clinic is not responsible for my individual performance or my ability to adhere to the diet. There are NO guarantees for individual weight loss or any other benefits.

In fact, I acknowledge that I have done my own research and am requesting that the Medical Clinic provide the B12 Shots & MIC Lipotropic SHOTS to me. I am fully informed of costs, risks and alternatives. I acknowledge that any medical ailments or personal issues preventing adherence to taking the B12 Shots & MIC Lipotropic SHOTS is not the fault or responsibility of Medical Clinic.

I fully understand that there is NO medical necessity to take MIC Lipotropic or B12 shots and that there are many alternatives that are less costly such as eating well balanced meals or taking oral supplements.

I agree that I will NOT to share any prescribed medications with any friends or family as doing such may be PRACTICING MEDICINE WITHOUT A LICENSE a crime in New Jersey.

I UNDERSTAND THERE ARE NO REFUNDS OR PARTIAL CREDITS FOR ANY REASON.

I request treatment with B12 or MIC-B12. The injection of B12 and MIC-B12 has been explained to me and my questions regarding such treatment have been answered to my satisfaction. The information given to me has been in clear terms and I understand the risks, benefits, possible side effects and complications of the treatment.

I UNDERSTAND THE RECOMMENDED DOSE FOR B12 IS 1ML INTRAMUSCULAR WEEKLY. Patient Initial **X** _____

I UNDERSTAND THE RECOMMENDED DOSE FOR MIC-B12 IS 1 TO 2 ML INTRAMUSCULAR OR SUBCUTANEOUSLY WEEKLY. (A DOSE OF 1 MLS AT BEGINNING OF WEEK, THEN A DOSE OF 1 MLS 3 DAYS LATER) Patient Initial **X** _____

I CERTIFY THAT I DO NOT HAVE AN ALLERGY TO SULFA. Patient Initial **X** _____

I CERTIFY THAT I DO NOT HAVE A LIVER OR KIDNEY IMPAIRMENT THAT I AM AWARE OF. Patient Initial **X** _____

Vitamin B-12 helps maintain good health and has been shown to be beneficial in helping to: Reduce stress, fatigue, improve memory and cardiovascular health, and maintain a a good body weight. It can also assist the body in converting proteins, fats and carbohydrates into energy and is necessary for healthy skin and eyes.

B12 Injections are better absorbed by the body since they go directly into the blood stream. Alternatives to B12 injections are Oral Vitamins, B12 Patch, Lozenges, Liquid drops and Nasal Spray

B12 / MIC (Lipotropic) Injections common side effects include but are not limited to:

1. Risks: I understand there is risk of mild diarrhea, upset stomach, nausea, a feeling of pain and a warm sensation at the site of the injection, a feeling, or a sense, of being swollen over the entire body, headache and joint pain
2. If any of these side effects become severe or troublesome I will contact my physician immediately
3. I understand that although rare Vitamin B12 or MIC injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking vitamin B12 or MIC injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of B12 or MIC injections, and such side effects should be reported to a physician to be evaluated for seriousness. Uncommon and dangerous side effects include:

X _____ _____

PATIENT Signature **STAFF Signature**

- rapid heartbeat
- chest pain
- flushed face
- muscle cramps and weakness
- difficulty breathing and swallowing
- dizziness
- confusion
- rapid weight gain
- tight feelings in the chest
- hives, skin rashes
- shortness of breath when there is no physical exertion and unusual wheezing and coughing.

4. Before starting vitamin B12 / MIC injections I will make sure to tell my Physician if I am pregnant, lactating or have any of the following conditions.

    - Leber's Disease
    - Kidney disease
    - Liver disease
    - An infection
    - Iron deficiency
    - Folic acid deficiency
    - Receiving any treatment that has an effect on bone marrow
    - Taking any medication that has an effect on bone marrow
    - An allergy to cobalt or any other medication, vitamin, dye, food or preservative

5. I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non prescription medications may result in side effects when they interact with the B12 Injection.
6. B12 Treatments: Once a week / MIC LIPOTROPIC with B12 once or twice per week.

I have been informed of the following:

- While all components generally have no side effects, doses must be taken at regular intervals. The injections are only effective temporarily. As soon as the effect of these drugs wear out, the body starts returning to normal.
- Some redness, minor discomfort, small bruising and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.
- Some people have experienced allergic reactions to the injections.
- Potential side effects include stomach upset and urinary problems due to the strain the injections place on the kidneys. Some patients have been unable to control their urine and/or had diarrhea.
- Depression is another possible side effect.
- It has been reported that B12 can cause peripheral vascular thrombosis, itching, and a feeling of swelling in the body.
- Unexplained pain may develop in unrelated parts of the body. Some people have experienced joint pains.
- Lipotropic injections change the function of the digestive system temporarily. This can result in extreme exhaustion.
- Weight loss can be inconsistent from one week to the next. There can be no guarantees as to the timetable of a weight loss program.
- Too much Methionine and Adenosine Monophosphate can potentially accumulate in the body and have the side effect of boosting the metabolic rate too high. If any abnormal heart racing occurs, I will contact my medical provider immediately.
- Vitamin B12 is contraindicated in Leber's hereditary optic neuritis, as it can cause blindness.

I understand that there is limited research and established clinical research with scientific studies to support safe use of B12 and or MIC Lipotropic Injections and that I may have unexpected negative results and that I have fully discussed this possibility with my primary care physician and I am willing to assume the risks.

I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments.

X_____ _____

PATIENT Signature **STAFF Signature**

PRINT PATIENT NAME: _____ **HCG DIET CERTIFICATION & INFORMED CONSENT**

I _____(hereafter "PATIENT") acknowledge and understand that DR. Maria Romanenko, DO/ New Age Medical Clinic PA (hereafter "Medical Clinic") is NOT my primary Medical Doctor and ALL medical decisions regarding any current or future health conditions should be addressed by my primary care physician. I have spoken to my primary care physician regarding the HCG Diet and he/she has no objections to my starting the program. Medical Clinic serves as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness.

I acknowledge that there are no guarantees relating to the effectiveness of the HCG Diet and that I have done my own research and have made a well informed decision to start the diet and agree that Medical Clinic is not responsible for my individual performance or my ability to adhere to the diet. There are NO guarantees for individual weight loss. No promises have been made that I will lose a particular amount of weight and I have done my own research about the HCG Diet and I assume responsibility for my performance.

I acknowledge that I have done my own research independent of Medical Clinic and am requesting that the Medical Clinic provide the HCG Diet to me and I assume complete responsibility for my performance. I am fully informed of costs, risks and alternatives. I acknowledge that Medical Clinic did not invent the HCG Diet and it is one of many clinics providing such service and my decision to do the HCG Diet is not based on any pressure from Medical Clinic.

I agree that ONCE I START THE DIET IT LASTS FOR ONLY 4 week, 6 week, 8 weeks from day I start diet. (depending on what I sign up for). THE DIET STARTS THE FIRST DAY OF THE FIRST INJECTION AND IS OVER 25 or 40 DAYS FROM THAT DATE! IF I STOP FOR ANY REASON THE DIET IS OVER WHEN THE 4 week, 6 week, 8 weeks PERIOD FOR WHICH I SIGNED UP REACHES 4 week, 6 week, 8 weeks FROM START DATE. DOING ½ the diet and resuming diet after stopping for more than one week is NOT permitted and that any additional monitoring required might incur an additional charge. Patient agrees he/she will not SPLIT diet into multiple diets.

I am certain I'll be ready to start diet when I start it. I acknowledge that any medical ailments or personal issues preventing adherence to diet is not the fault or responsibility of Medical Clinic. I understand **Insurance does NOT cover the HCG Diet** and that New Age Medical Clinic will not submit any receipts on my behalf.

I agree that I will NOT to share any prescribed medications with any friends or family as doing such may be PRACTICING MEDICINE WITHOUT A LICENSE and is a crime in New Jersey.

NO PROMISES HAVE BEEN MADE TO PATIENT FOR WEIGHT LOSS!

Patient acknowledges they are 1) above average intelligence 2) have no pending medical issue pressuring them into trying our services 3) have independently researched services they are receiving 4) have not been pressured into purchasing our services 5) can afford to pay for services without negatively affecting their lifestyle or anyone's wellbeing who depends upon them financially 6) they have independently reviewed services they are purchasing with their Primary Care Physician and that Physician has no objections with their participation in such services.

NEW AGE MEDICAL CLINIC PA DID NOT INVENT HCG DIET!! PATIENT HAS EVALUATED OTHER HCG DIET PROVIDERS AND CHOSE OUR OFFICE AFTER THOUROUGHLY RESEARCHING THE DIET PROGRAM!

I UNDERSTAND THERE ARE NO REFUNDS OR PARTIAL CREDITS FOR ANY REASON.

PATIENT AGREES TO TEXT OR CALL OFFICE EVERY SINGLE DAY HE/SHE DOES NOT LOSE A POUND.

NO EXPECTATION HAS BEEN GIVEN THAT PATIENT WILL LOSE A POUND PER DAY!! THAT IS OUR GOAL BUT NOT PROMISES HAVE BEEN MADE TO PATIENT!!

X_____ _____

PATIENT Signature **STAFF Signature**

Maria Romanenko, DO/ New Age Medical Clinic PA (hereafter "Medical Clinic") does NOT treat any diseases and any services performed by staff, are designed to improve overall nutritional wellbeing of our patients. **The HCG Diet requires daily injections to be administered to patient. No published studies have shown that the HCG Diet is effective. HCG has not been approved by FDA for weight loss.**

Since 1975 the FDA has required all marketing and advertising of HCG to state the following: **"HCG has not been demonstrated to be effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or 'normal' distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets."**

"HCG is a hormone extracted from urine of pregnant women. It is approved by FDA for treatment of certain problems of the male reproductive system and in stimulating ovulation in women who have had difficulty becoming pregnant. No evidence has been presented, however, to substantiate claims for HCG as a weight-loss aid."

Patient agrees to consult with primary care physicians as to the safety and efficacy of the treatments provided by staff at Medical Clinic given their familiarity with patient's underlying medical history and response to medications received. Patient has not been pressured to make any decision and I have had the opportunity to **discuss all treatments proposed with my primary care physician** and given the opportunity to ask questions.

Patient confirms he/she is making an informed decision based on all the information provided by Medical Clinic and my primary healthcare practioner(s) and I have had the opportunity to review any peer reviewed scientific journals that may have reported on the therapies proposed. Such journals can be reviewed for free at UMDNJ Library 30 12th Ave. Newark NJ, 07101, Phone: 973-972-4580 or accessed by subscribing online at http://www.questia.com

Treatments may have risk factors listed or cause the side effects listed below. However, as **these treatments might be considered experimental in nature**, as they may not have been funded for widespread scientific review under controlled conditions and have not been reported in peer reviewed scientific journals; there may be some side effects that we cannot predict.

WOMEN of Child Bearing Years: I certify that there is NO possible way that I could be pregnant. Women in child bearing years must receive pregnancy test ($20 extra) if they have had sexual intercourse since last menstrual period unless they have had a hysterectomy. I agree that I will avoid unprotected sex and use multiple methods of birth control during the time frame while on HCG Diet. **MEN** agree to not have unprotected sex and not attempt to conceive children until 60 days after completing HCG DIET. (Patient Initial)_____

The patient's diagnosis, if known: _____**obesity |** _____**over weight |** _____ **(other)**

- The nature and purpose of a proposed treatment or procedure: **Hcg Diet**
- The benefits of a proposed treatment or procedure: **Weight Loss**
- Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance): **change diet, exercise, prescribed medication, OTC medications, surgery, psychiatric therapies**
- The risks of not receiving or undergoing a treatment or procedure: **stay the same or get worse**
- The benefits of not receiving or undergoing a treatment or procedure: **save money or condition may resolve itself**

HCG Diet: Side effects / Potential risks or discomfort: *REMEMBER: ALL WOMEN WHO GET PREGNANT HAVE HAD HCG IN THEIR BODY AT FAR HIGHER LEVELS THAN THOSE TAKING HCG AS PART OF THE HCG DIET. Dehydration is common side effect of HCG Diet. Hair loss is a rare side effect of dieting especially with highly restrictive diets. Take supplements and consult your primary care MD if you have a history of hair loss.* The HCG medication manufacturer reports that on rare occasions some patients taking HCG at HIGH levels 10,000+ I.U.'s (50 times the HCG Diet Dosage) may experience headaches, mood swings, depression, blood clots, confusion, and dizziness. Some women also develop a condition called Ovarian Hyperstimulation Syndrome (OHSS); symptoms of this include pelvic pain, swelling of the hands and legs, stomach pain, weight gain, shortness of breath, diarrhea, vomiting/nausea, and/or urinating less than normal. In some women, being on the HCG diet protocol and taking HCG, may cause delayed menstrual cycle, early menstrual cycle, heavier flow, lighter flow and or heavy cramping. These conditions also are symptoms that women may experience during pregnancy.

X_____ _____

PATIENT Signature **STAFF Signature**

Patient Name_____ Age_____ Date_____

The New Age Medical Clinic PA / Dr. Maria Romanenko, DO does NOT treat diseases and any services performed by staff / treatments received by patients, are designed to improve overall nutritional and general wellbeing of our patients.

Patient agrees to consult with their primary care physician as to the safety and efficacy of the treatments provided by staff at New Age Medical Clinic PA given their familiarity with patient's underlying medical history and response to medications received in the past.

Patient acknowledges that they have **not been pressured** to make any decision and have had the **opportunity to discuss all treatments proposed with their primary care physician** and given the opportunity to ask questions. Patient has made an informed decision based on all the information provided by primary healthcare practioner(s) and has had the opportunity to review any peer reviewed scientific journals that may have reported on the therapies proposed. Such journals can be reviewed for free at UMDNJ Library 30 12th Ave. Newark NJ, 07101, Phone: 973-972-4580 or accessed by subscribing online at http://www.questia.com

WOMEN of Child Bearing Years:
I certify that there is NO possible way that I could be pregnant X_____ (women in child bearing years must receive pregnancy test if they have had sexual intercourse since last menstrual period unless they have had a hysterectomy.)
I agree that I will either refrain from sexual intercourse during heavy metal detoxification for 60 days since last treatment or take precautionary measures with birth control during this time frame. X_____

Treatments may cause the side effects listed below. However, as these treatments are preventive and off label use, and they may not have been funded for widespread scientific review under controlled conditions and have not been reported in peer reviewed scientific journals; there may be some side effects that we cannot predict.

Side effects / Potential risks:

Kidney Toxicity:
Kidney toxicity is related to size (quantity) of the dose; extremely rare. Experienced doctors adjust dosage so that the dose will not harm the kidney. Indeed, research has shown that, properly administered, DMSA therapy is thought to improve kidney function, especially if there is any impairment present to this vital organ.

Diarrhea, **nausea**, **vomiting**, **appetite loss** and **rashes.** As with all chelating medications, kidney and **liver** function needs to be closely monitored.

Patient acknowledges that there are no definitive tests to determine the exact levels of toxic metals in your system. Blood, hair, fecal, radiographic, or challenge urine toxicity testing is only a general determinant that toxic metals are in your system; as metals settle into different organs depending on age, metal and nutritional status. We utilize challenge urine toxicity testing as a general indicator of toxic metals. Many laboratory tests are formulated to show heavy metal levels without use of a chelating agent (DMSA) use of such chelating agent will greatly increase the metal levels shown and will exaggerate the results by pulling the metals from soft tissue and bone; and therefore can not accurately predict levels of heavy metals; but will show a rough estimate of what metals are coming out of your system.

There are safe levels of toxic metals according to government standards- but we don't think it anyone should purposely expose themselves to any known carcinogens or toxic substance.

Our goal is to eliminate completely ALL toxic metals from your system and environment. We don't know what the exact levels of metals that might cause certain individuals to get sick, but we do know there are millions of people that have unexplainable ailments that quite possibly could be caused by poor nutrition, viruses, radiation, pesticides/chemical exposure or toxic metal (lead, mercury, cadmium,

X_____ _____ _____
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aluminum etc.) exposure. Elimination of toxic metals should be addressed in conjunction with improved nutrition and healthy lifestyle choices.

I understand that Chelation Therapy is a standard therapy widely approved for the treatment of lead toxicity and that DMSA is an FDA-approved drug for only lead toxicity; however, the use of DMSA for treating any other diseases or preventing diseases or chelating other metals besides lead is what is called "off label" use of the drug. The usage of DMSA is considered controversial for the generalized treatment of low level trace amounts of lead, mercury and other metals, and a minority of the medical community accepts the view that it is of benefit in the treatment of such disorders. Opponents consider such use of DMSA to be "experimental."

No promises have been made to the effectiveness of proposed treatments.

The patient's diagnosis, if known: possible metal toxicity | trace amounts of heavy metals | preventive medicine | (other)_____
The nature and purpose of a proposed treatment or procedure: DMSA (trace amounts of lead possible environmental)

- **Benefits:** The possible but NOT DEFINITE benefits of a proposed treatment or procedure: not certain, possible reversal of disease or prevention of disease.
- **Alternatives: (regardless of their cost or the extent to which the treatment options are covered by health insurance):** statin drugs | healthy eating | surgery | do nothing | consult experts
- **The risks of not receiving or undergoing a treatment or procedure:** stay the same | get worse | possibly none
- **Benefits of not receiving or undergoing a treatment or procedure:** save money | condition may resolve itself
- **Costs: Initial Consult with testing supplies (from lab) and testing medication: $50 plus lab costs to test toxicity (Doctor's Data LAB is $75 per test—getting started will require two tests --you pay them direct (you can try to submit to insurance- if they don't pay- Doctor's Data will charge more); 3 day Cycles are $375 each (includes office visits, medication and after hours support). Most people do 10-12 cycles. If you need special decreased dosing additional charge applies. Monthly Blood work required (no included in price). Subsequent follow-up urine testing for metals required $75 each (not included in price). Buy 10 Cycles at one time get $1250 discount (ten cycles package costs $2500). SORRY NO REFUNDS**

SUPPLEMENTS REQUIRED BEFORE, DURING OR AFTER DMSA (NOT INCLUDED IN PRICE)

- **Vitamin C**
- **NAC**
- **Alpha Lipoic Acid**
- **MSM**
- **Vitamin E**
- **Daily Multi Vitamin**

STOP TAKING 24 HOURS BEFORE DMSA:

1. Do not take Garlic, NAC, Cysteine, Methionine, MSM, or other sulfur containing supplements while taking DMSA. These supplements inactivate DMSA. **Stop during 3 days of DMSA cycle.**
2. NAC 100-300 mg/day during off days (DMSA depletes Cysteine). **Stop during 3 days of DMSA cycle.**
3. Do not eat chlorella, garlic, onions, brussel sprouts, cabbage, and cilantro while taking DMSA. They chelate Mercury, but inactivate DMSA. **Stop during 3 days of DMSA cycle.**
4. Buffered Vitamin C 1000+ mg/day. It is a natural chelator. **Take Everyday**
5. No tuna, bottom feeders, swordfish or shell fish. **Eliminate from Diet 7 days before DMSA cycle.**
6. **Start taking alpha-lipoic acid 100mg with each DMSA dose after successfully completing 4 rounds of DMSA (each round is 3 days). This is thought to help remove metals from brain.**
7. Take Vitamin E 400mg Daily. **Take Everyday**

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**

8. Replete Zinc 30 mg daily. **Take 24 hours after DMSA, not while on it. Stop taking 24 hours before DMSA.**
9. If on DMSA (Thorne Captomer, Chemet, or Succimer), check CBC (complete blood count) and CMP (complete metabolic panel) after every 2 cycles.
10. Take 500mg MSM 7 days before and stop 24 hours before starting round of DMSA, and on off days between cycles.
11. Take **Daily Multivitamin / Mineral** everyday. **Stop during 3 days of DMSA cycle.**

Recommended Adult Dosage

Practitioners report minimal incidence of side effects associated with a dosing protocol that entails 500 mg DMSA, 3X/day) 30 Minutes before Breakfast, Lunch & Dinner- Don't Combine Doses. 500mg capsule, 3X per day, for 3 days. Then do NOT take any DMSA for 11 days. If you immediately get a headache start with LOWER Dose (call office –additional medication additional charge). Stop DMSA if rash appears on skin. This is a pretty common side effect. Resume DMSA 4 weeks after rash resolves.

Adverse Reactions

Negative or adverse reactions are rare and are strongly related to **LENGTH** of usage and **NOT** dosage levels. Therefore, it is recommended to start treatment with a mid to high level of DMSA to avoid adverse reactions. Should a patient notice any adverse reactions simply discontinue usage and allow your body to recover. It is recommended that patients wait 4 weeks before restarting chelation after any adverse reactions have been noted, please discuss with our staff. While chelating avoid eating fish and shellfish.

How Long Do I Need To Chelate?

Most individuals do 10-12 cycles to significantly rid their bodies of heavy metals. Note that a cycle is 2 weeks as stated above (3 days on, and 11 days off.) This means you should chelate for approximately 5-6 months. At the end of your last chelation cycle it is recommended that you take the urine challenge to assess the levels of metals coming out of your body. The ideal is to keep chelating until the results of challenge testing is extremely low or undetectable. Hair analysis and blood tests cannot accurately show your body burden for heavy metals, such tests are only useful for acute/recent exposures to heavy metals.

Patient acknowledges they are above average intelligence, have no pending medical issue pressuring them into trying our services and have independently researched services they are receiving, they have not been pressured into purchasing services and can afford to pay for services without negatively affecting their lifestyle or anyone's wellbeing who depends upon them financially.

PATIENT HAS NO SULFA ALLERGIES

X_____ _____ _____

PATIENT Signature **Date** **STAFF Signature**