Pre and Post-Treatment Patient Instructions

You are to refrain from bleaching, tweezing or waxing of the area to be treated for a minimum of 6 weeks prior to treatment.

Prior to Treatment

- Do not pluck, wax, thread, tweeze or undergo electrolysis in the areas you wish to have treated for 4 weeks prior to laser hair removal.
- The area to be treated should be shaved.
- For better results, patients are to avoid sun exposure, tanning beds and self-tanning creams. Do not tan the areas to be treated for 2-4 weeks prior to treatment, and throughout the course of your treatment. A broad spectrum (UVA/UVB) sun block with an SPF of 30 or greater should be applied to the area(s) to be treated whenever exposed to the sun. However, if sun exposure is not avoidable, a reduced energy fluence may be used for your treatment, and in this case treatment sessions need to be increased. Very recent sun exposure may result in the cancellation of your treatment.
- Wear loose fitting, comfortable and washable clothing.
- For comfort and pain relief, you may take regular strength Tylenol if prescribed by your Physician, and if this does not interfere with any other medications you may be taking.
- Discontinue any irritant skin agents for 2 to 3 days prior to treatment.

After Treatment

- Some redness, swelling and a mild sunburn sensation should be noticed in the treatment area for up to 2 hours after treatment. Clients should not feel any significant discomfort after treatment.

- Apply a Vitamin E Gel or Aloe Vera Gel to the treated area twice a day for 5 to 7 days after treatment, or until the “sunburned” feeling has subsided. Gently clean area twice daily.
- Ointment can be applied to the area to prevent drying and crusting. If crusting develops it should be allowed to fall off naturally (no picking).
- You may apply cold compresses to the area to reduce any redness and swelling. Do not use chemical cold packs. Post treatment cooling is highly recommended for darker skins.
- Apply sunscreen for 6 weeks over the treated area, and throughout the course of your laser treatments. A broad spectrum (UVA/UVB) sun block with a minimum SPF 30 must be applied 15 minutes prior to casual sun exposure, and prolonged sun exposure requires repeated applications every 2 hours, and also reapplied after swimming.
- Avoid perfumes, strong soaps, makeup and deodorants to the treatment area until the stinging and redness has subsided. Avoid hot baths and hot tubs and also working out for 24 hours after treatment. Avoid any facial irritants such as glycolic, retinoid creams, chemical peels, microdermabrasion etc., for 7 days after treatment.
- Do not pluck or wax after your treatment. Shaving of the area is allowed between laser treatments as necessary. Please allow 3 days post laser treatment to begin shaving.
- Blistering can occur during the first 3 days following treatment. The areas should be kept clean and treated with care. If an open area or blister develops, use a topical antibiotic ointment, like Neosporin, keeping it moist until area has healed. For facial areas that blistered, use extreme caution when applying or removing makeup. Rough removal of makeup can increase the incidence of post treatment complications.
- When bathing, if the treated area is irritated, do not rub with a face cloth or towel. The area should be patted dry.
- Pustules or pimples may develop in the first few days following treatment. The areas should be kept clean and treated with care. Avoid excessive sweating.
- Histamine/Hives: some patients develop raised papules similar to hives. This irritation usually subsides in a few hours.
- With bikini areas, panty elastic at the leg should be avoided for several days after treatment. The irritation of the elastic can lead to rash or blistering.

NEW AGE MEDICAL CLINIC PA **INTAKE EVALUATION** 90 Millburn Ave., Suite 201 Millburn NJ 07041 (908) 598-0509

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** | ☐ **Natural Awakenings Magazine** | ☐ **Signs** | ☐ **Car Sign** | **referred by** | ☐ **business card** | **other**_____

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:

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.

1. 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)

   Please describe your skin type (check ALL that apply)

   ☐ Normal ☐ Prone to redness
   ☐ Combination normal-oily ☐ Sensitive
   ☐ Combinations normal-dry ☐ Very Acne prone
   ☐ Oily

   Other (please describe):_____

Have you experienced any of the following (mark ALL that apply):

- ☐ Sunbathing, using suntan beds, sunless tanner and or spray tans within past 2 weeks
- ☐ Waxing, plucking or electrolysis in treatment area within past 6 weeks
- ☐ Facial laser resurfacing within past two years
- ☐ Chemical peeling within past 3 months
- ☐ Permanent make-up or facial tattoos within past two years
- ☐ I have not had any of the above procedures within indicated time frame (initial)

Please use following space for comments:

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2. **Menstrual/Birthing History** Last Menstrual Cycle:

☐ Age of first Menses:	☐ # of Pregnancies:
☐ # Of Days of Menses:	☐ # of Miscarriages:
☐ Length of Cycle:	☐ # of Abortions:
☐ Birth Control Type:	☐ # of Live Births:

3. When and where did you last receive health care?

   For what reason?

4. FEMALES: Is it possible you may be pregnant? ◯ yes ◯ no | If "yes" How far along are you or may you be?

   Are you using birth control? ◯ yes ◯ no | (if "yes" What kind?)

5. Do you have any infectious diseases? ◯ yes ◯ no

   If "Yes" Please Identify:

6. **Family History** (check those that apply)

1. FAMILY HISTORY

Mother:
Living ◯ yes ◯ no |(age at death) (cause death) |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 death) |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 death) |Cancer ◯ yes ◯ no | Heart Disease ◯ yes ◯ no | Stroke ◯ yes ◯ no | Diabetes ◯ yes ◯ no | Mental Illness ◯ yes ◯ no | Kidney Disease ◯ yes ◯ no |

2. **You weight for past 10 years:** Past Max Weight: Past Min Weight:
3. **Blood Pressure:** What is your most recent blood pressure reading? / Taken:
4. Digestion Issues:

☐ Nausea | ☐ Vomiting | ☐ Diarrhea | ☐ Blood in stool | ☐ ABD Pain | ☐ Bloating | ☐ Gas |
☐ ABD Distention | ☐ Constipation | ☐ Incomplete Evacuation | ☐ Small Round Stool | ☐ Hard Stool |
☐ Significant Residual When Wiping | ☐ ABD cramping | ☐ Rectal bleeding | ☐ Hemorrhoids (internal or external)|
☐ Diverticulosis / diverticulitis | ◯ yes ◯ no Other digestive concerns if any (if "yes" describe) :

BM FREQUENCY: Number of times Per Day: 1 ◯ 2 ◯ 3 ◯ 4 ◯
If don't typically have a daily BM how often do you evacuate? ◯ 1-2 per week | ◯ 3-4 per week | ◯ 5-6 per week | ◯ less than once a week

Does it feel like there is more feces stuck in you after having bowel movement? ◯ yes ◯ no

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 | Bloody Stool: ◯ yes ◯ no |

Hemorrhoids: ◯ yes ◯ no

Last Bowel Movement Previous Interventions: ◯ None | ◯ Laxatives / Enemas / ◯ Other (describe):

Frequency of Bowel Movements Color Consistency: (check all that apply): ☐ thin, ☐ thick, ☐ hard, ☐ soft, ☐ watery, ☐ small round, ☐ clay like

5. **Any Diagnosis of Cancer or non-malignant tumors:**

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):

6. **Childhood Illness:** (check any that you have had):

☐ Scarlet Fever | ☐ Diphtheria | ☐ Rheumatic Fever | ☐ Mumps| ☐ Measles| ☐ German Measles |
☐ Chicken Pox | Anything else (please describe):

7. **Immunizations:** (check any that you have had):

☐ Polio | ☐ Tetanus | ☐ Rubella/Mumps | ☐ Pertussis | ☐ Diphtheria | ☐ HiB |
☐ Hepatitis-B | ☐ Chicken Pox | ☐ Pneumonia | ☐ Flu | ☐ Other

8. **Hospitalizations and Surgeries:**
When and what happened:

X-Rays / CAT Scans / MRIs / NMRs / Special Studies:
When and what happened:

9. **Emotional/Psychiatric :** ☐ Mood Swings | ☐ Nervousness | ☐ Mental Tension | ☐ Irritability | ☐ Depression | ☐ Grief | ☐ Obsessive Thinking | ☐ Current thoughts of hurting self or others

Describe:

10. **Energy and Immunity :** ☐ Fatigue | ☐ Slow Wound Healing | ☐ Chronic Infections | ☐ Lyme Disease| ☐ Chronic Fatigue | ☐ Candida / Yeast Infections

11. **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 | ☐ Teeth Grinding | ☐ TMJ/Jaw Problems | Hay Fever

12. **Respiratory :** ☐ Pneumonia| ☐ Frequent Common Colds | ☐ Difficulty Breathing | ☐ Emphysema | ☐ Persistent Cough | ☐ Pleurisy | ☐ Asthma | ☐ Tuberculosis | ☐ Shortness of Breath

Cardiovascular :

☐ Heart Disease | ☐ Chest Pain | ☐ Swelling of Ankles | ☐ High BP | ☐ Palpitations/Fluttering | ☐ Stroke |
☐ Bruising | ☐ Heart Murmurs | ☐ Rheumatic Fever | ☐ Varicose Veins | ☐ Abnormal Bleeding | ☐ Pain in Calves

☐ Heart Attack (MI) ☐ Angina | ☐ Edema | ☐ Congestive Heart Failure

When Diagnosed: What was exact diagnosis:

Who was Doctor: Dr's Phone#:

All Treatment(s) received:

Current Restrictions: ◯ yes ◯ no (if yes describe):

13. **Gastrointestinal :** ☐ Ulcers | ☐ Changes In Appetite | ☐ Nausea/Vomiting | ☐ Epigastric Pain | ☐ Passing Gas | ☐ Heartburn | ☐ Belching | ☐ Gallbladder Disease | ☐ Liver Disease | ☐ Hepatitis A, B or C | ☐ Hemorrhoids | ☐ Abdominal Pain | ☐ Diverticulosis | ☐ Diverticulitis | ☐ IBS
14. **Genito-Urinary Tract :** ☐ Kidney Disease | ☐ Painful Urination | ☐ Frequent UTI | ☐ Frequent Urination | ☐ Heavy Flow ☐ Kidney Stones | ☐ Impaired Urination | ☐ Blood in Urine | ☐ Frequent Urination at Night
15. **Female Reproductive / Breasts :** ☐ Irregular Cycles | ☐ Breast Lumps/Tenderness| ☐ Nipple Discharge | ☐ Heavy Flow | ☐ Vaginal Discharge | ☐ Premenstrual Problems | ☐ Clotting | ☐ Bleeding Between Cycles | ☐ Menopausal Symptoms ☐ Difficulty Conceiving | ☐ Painful Periods

    Describe Current Concerns:
16. **Male Reproductive :** ☐ Erectile Dysfunction | ☐ Prostrate Problems | ☐ Testicular Pain/Swelling | ☐ Penile Discharge
17. **Musculoskeletal :** ☐ Neck/Shoulder Pain | ☐ Muscle Spasms/Cramps | ☐ Arm Pain | ☐ Upper Back Pain | ☐ Mid Back Pain ☐ Lower Back Pain | ☐ Leg Pain | ☐ Joint Pain

18. **Neurologic** ☐ Vertigo/Dizziness | ☐ Paralysis | ☐ Numbness/Tingling | ☐ Loss of Balance | ☐ Seizures/Epilepsy | ☐ Migraines | ☐ Stroke | ☐ Memory Loss | ☐ Weakness on one side of body

    When Diagnosed: What was exact diagnosis:

    Who was Doctor: Dr's Phone#:

    All Treatment(s) received:

    Current Restrictions: ◯ yes ◯ no (if yes describe):

19. **Endocrine** ☐ Hypothyroid | ☐ Hypoglycemia | ☐ Hyperthyroid | ☐ Diabetes Mellitus | ☐ Diabetes Insipidus | ☐ Night Sweats | ☐ Feeling Hot or Cold

20. **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):

    f. Occupation: Employer:

    Hours/Week: Do you enjoy work? ◯ yes ◯ no (Why Not)

    g. Nicotine Use (what form):_____ (past or present) ◯ ◯

    Amount:_____ Frequency:_____

    h. Alcohol Use (what form): ◯ yes ◯ no (if no when was last time you consumed) :

    Amount: Frequency:

    i. Recreational Drugs: ◯ yes ◯ no (if no when was last time you consumed) :

    Type(s)

    Amount: Frequency:

    j. Have you experienced any major physical traumas? ◯ yes ◯ no
    Describe:

    k. How many 8 oz glasses of non-caffeinated, non-carbonated beverages do you drink per day?

    l. Interests and Hobbies:

Have You Been Able To Follow Prescribed Medications/Treatments? ◯ yes ◯ no If “no” why not?

Regular Physician: Phone:

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

I _____ (patient name) acknowledge and understand that:

1) Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA 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) The NEW AGE MEDICAL CLINIC PA 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 New Age Medical Clinic PA
4) All supplied medical information is accurate and forthcoming;
5) I have informed my primary care physician about services I am to receive at NEW AGE MEDICAL CLINIC PA 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 NEW AGE MEDICAL CLINIC PA 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 NEW AGE MEDICAL CLINIC PA I had previously made a decision independent of NEW AGE MEDICAL CLINIC PA to try the services offered at NEW AGE MEDICAL CLINIC PA.
8) I understand that there are NO REFUNDS and that I am financially able afford the services for which I am seeking and I have not been made any promises as to the results or effectiveness of such services/treatments and have been provided with costs for services and I can afford services I am requesting without creating a hardship to myself or those depending on me financially.
9) I authorize New Age Medical Clinic PA to charge my credit card (amex, visa, mastercard or discover) if supplied to them, by me, to pay for services.
10) I consent to live encrypted audio & video monitoring (ie: webcam / FaceTime) during intake, physical exam and instructional sessions to Medical Director or other medical staff as necessary when off site. No video or audio sessions to be saved.
11) I consent to reciving TEXT / SMS/ Imessages to inform me about pending appointments, promotions and communicate regarding patient care.

Patient Signature

_____

Signature of Health Care Provider

I _____ (hereafter "PATIENT") certify that I am a BONIFIED Patient of New Age Medical Clinic PA 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 New Age Medical Clinic PA, shall be deemed detrimental to their business. PATIENT seeks to benefit from the services provided by New Age Medical Clinic PA for improved health ONLY and New Age Medical Clinic PA seeks to benefit from fees charged to PATIENT for services rendered. 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 NEW AGE MEDICAL CLINIC PA was to promote a competing business venture or to bring about any action or publicity that might cause financial harm to New Age Medical Clinic PA, its shareholders or employees; PATIENT agrees to be personally liable for all financial costs, opportunity costs, employee hourly fees wasted servicing PATIENT and include legal fees for collection of damages.

PATIENT and New Age Medical Clinic PA agree that all disputes will be settled by binding arbitration through American Arbitration Association (AAA). New Age Medical Clinic PA, both PATIENT and New Age Medical Clinic PA agree to the exception to arbitration that New Jersey Superior Court of Essex, Bergen or Monmouth County (or court of competent jurisdiction) is hereby authorized, 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 any disputes. 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 they have had ample opportunity to have legal counsel review this agreement and are not being coerced in any way to sign this agreement.

By:

NEW AGE MEDICAL CLINIC PA

_____

Patient Signature

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: / / TODAY'S DATE:

X (signature)

IMMEDIATELY FAX RECORDS TO:
NEW AGE MEDICAL CLINIC PA **90 Millburn Ave., Suite 201, Millburn NJ 07041**
FAX: 973-210-4500 PHONE: (908) 598-0509

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 address:

NEW AGE MEDICAL CLINIC PA **90 Millburn Ave., Suite 201, Millburn NJ 07041 PHONE: 973-313-0028**

Or 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 specifically required or permitted by law.

HIPPA

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.

(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.

_____ Signature of Patient

_____ Signature of Staff

CONTRINDICATIONS or CONCERNS requiring more information prior to participating in our services:

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 |***Any existing medical condition not listed on the intake forms*** ◯ yes ◯ no

EXPLAIN ALL "YES" ANSWERS:

_____

Do you currently or ever had any of the following:

yes	no		yes	no	
◯	◯	severe hemorrhoids	◯	◯	heart attack / stroke
◯	◯	painful abdominal hernia	◯	◯	diverticulitis (current infection)
◯	◯	renal insufficiency	◯	◯	ulcerative colitis
◯	◯	recent colon or rectal surgery	◯	◯	Crohn's disease
◯	◯	cirrhosis of the liver	◯	◯	severe or internal hemorrhoids
◯	◯	abnormal bleeding or clotting	◯	◯	tumors in the rectum or colon
◯	◯	chronic dehydration	◯	◯	intestinal perforation
◯	◯	fissures or fistula	◯	◯	blood in stool

Please explain all yes answers

_____

SIGNATURE

ONLY APPLIES TO CLIENTS 64 & Older

MEDICARE PRIVATE CONTRACT This agreement is entered into by and between NEW AGE MEDICAL CLINIC PA / Maria Romanenko, DO, (hereinafter called "Physician"), whose principal medical office is located at Suite 201, 90 Millburn Ave., Millburn NJ 07041 and (PRINT PATIENT NAME)
ADDRESS:

A. Background

A change in the Social Security Act, effective January 1, 1998, permits Medicare beneficiaries and physicians to contract privately outside of the Medicare program. Under the law as it existed prior to January 1, 1998, a physician 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 physicians and beneficiaries to enter into private arrangements through a written contract under which the Beneficiary may agree to pay the Physician more than that which would be paid under the Medicare program.

However, beneficiaries and physicians who take advantage of this provision are not permitted to submit claims or to expect payment for those services from Medicare. This agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

B. Obligations of Physician

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.
2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.
3. Physician acknowledges that (s)he will not execute this contract at a time when the Beneficiary is facing an emergency or urgent healthcare situation.
4. Physician 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. Physician agrees to submit copies of this contract to the Clinics for Medicare and Medicaid Services (CMS), upon the request of the CMS.

C. Obligations of Beneficiary

1. Beneficiary or his/her legal representative agrees to be fully responsible for payment of all items or services furnished by Physician and understand 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 Physician for such items or services.
3. Beneficiary or his legal representative agrees not to submit a claim to Medicare unless the filing of such claim is required to obtain secondary coverage for Physician's charges. Beneficiary agrees not to ask Physician to submit a claim to Medicare
4. Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by Physician 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 physicians 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 physicians 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 Clinics for Medicare and Medicaid Services (CMS) has the right to obtain copies of this contract upon request.

ONLY APPLIES TO CLIENTS 64 & Older

D. Physician's Status

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

E. Term and Termination

This agreement shall become effective today and shall continue in effect until one year from now. Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician 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.

F. Successors and Assigns

The parties agree that this agreement shall be fully binding on their heirs, successors, and assigns.

The parties hereto, intending to be legally bound by signing this agreement below ONLY if 64 Years of age or older or currently receiving medicare benefits and under

64 years of ag., have caused this agreement to be executed on the date written below.

◯ I am under 64 am not on Medicare this does NOT apply to me

◯ I am 64 or older I agree to terms of Medicare opt out agreement

NEW AGE MEDICAL CLINIC PA

_____ _____ Date

Name of Patient (printed) Signature of Staff

Signature

_____

NEW AGE MEDICAL CLINIC

90 Millburn Ave, Suite 201
Millburn, NJ 07041
973-313-2800

INFORMED CONSENT FOR LASER HAIR REMOVAL

Client's Name: _____ Date: _____

The purpose of laser hair removal is to diminish or remove unwanted hair. This procedure requires more than one treatment session. Most clients will need between 6 – 8 sessions. Usual intervals for the first 3 sessions are 4 to 6 weeks on the face and 8 to 10 weeks on the body, increasing the intervals as treatment progresses.

The total number of treatment sessions may vary among individuals. On rare occasion there may be a client that does not respond to treatment. Hair follicles are closely intertwined with the skin and body and respond to internal physiological changes. This is why there can be no guarantees or promises of "all the hair gone forever" from a certain area.

I authorize New Age Medical Clinic, PA. and its designated staff to perform Laser Hair Removal on my body or face. I understand that Laser Hair Removal is an FDA –approved treatment method for removing unwanted hair. I have been advised of the possible adverse reactions which are as follows:

1. **Short term effects** may include reddening, swelling, bumps, mild burning, temporary bruising or blistering. Hyperpigmentation (browning of skin) and Hypopigmentation (lightening of skin), although rare, may occur. These conditions usually resolve within 3 – 6 months, but permanent color change is a rare risk, less than 1%. Avoiding sun exposure before and after treatment reduces the risk of color change.
2. **Infection** following treatment is quite unusual, but bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can be stimulated by laser treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional skin treatments or medical antibiotics may be necessary.
3. **Allergic reactions**, although very rare, may occur. Local skin allergies to topical preparations, tape, or preservatives used in cosmetics can occur.
4. However slight, there is a **risk of scarring.**
5. **Eye protection** must be worn at all time because exposure to laser light could harm one's vision.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of Laser Hair Removal treatments. Before each treatment I will inform the laser technician if I have any changes in my medical condition or taken any new medications since my last treatment or if I have tanned the areas to be treated either by sunlight or artificially. I understand that tanning and some medications can make my skin photosensitive. I also understand that either of the aforementioned conditions could cause the laser to damage my skin. I also agree to comply with the recommended aftercare instructions which are crucial for healing and prevention of scarring and hyperpigmentation. I hereby release New Age Medical Clinic, PA and its designated staff from liability associated with the above.

ACKNOWLEDGEMENT:

My questions regarding the Laser Hair Removal procedures have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release New Age Medical Clinic, PA and all staff from all liabilities associated with the above indicated procedure.

Client/Guardian Signature: _____ Date: _____

Laser Technician Signature: _____ Date: _____