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**

PHYSICIAN - PATIENT ARBITRATION AGREEMENT

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE & OTHER ISSUES DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice or any tort or cause of action between the parties arising from any communication in any form related to services rendered or not rendered and whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by New Jersey law, and not by a lawsuit or resort to court process except as New Jersey law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided or not provided or communications made between the parties in any form (in person, over phone, text message, fax, email etc.), including any family or heirs of the patient and the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court and all class action cases against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be resolved by means of binding arbitration before a single arbitrator in accordance with the then existing Commercial Arbitration Rules of the American Arbitration Association, including the Optional Rules for Emergency Measures of Protection. The arbitrator shall be a practicing attorney or retired judge with at least fifteen years total working experience as such. The arbitration shall be held in New Jersey or any other place agreed upon at the time by the parties. No demand for arbitration may be made after the date when the institution of legal or equitable proceedings based on such claim or dispute would be barred by the applicable statute of limitation. The arbitrator is not authorized to award punitive or other damages not measured by the prevailing party's actual damages.

A party may apply to the arbitrator seeking injunctive relief until an arbitration award is rendered or the dispute is otherwise resolved. A party also may, without waiving any other remedy, seek from any court having jurisdiction any interim or provisional relief that is necessary to protect the rights or property of that party pending the arbitrator's appointment or decision on the merits of the dispute. If the arbitrator determines that a party has generally prevailed in the arbitration proceeding, then the arbitrator shall award to that party its reasonable out-of-pocket expenses related to the arbitration, including filing fees, arbitrator compensation, attorney's fees and legal costs.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4: Revocation: This agreement may be revoked by written notice delivered to the New Age Medical Clinic PA within 30 days of signing.

Article 5: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first contact with patient.

AGREED to Article 5: **X**_____

PATIENT SIGNATURE

Article 6: Severability Provision: If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

AGREED: **X**_____ AGREED: X_____

PATIENT SIGNATURE New Age Medical Clinic PA

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

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 I will not engage in any ill intentioned acts and agree any action taken by me that create a financial harm or potential harm to Medical Clinic'as reputation or hinders business or fosters the development of competing medical practice(s) of 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 or that PATIENT's motivation for engaging the time, efforts and expertise of the staff of Medical Clinic to promotes a competing business venture or brings 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, legal fees for defense, lost employee hourly fees and legal fees for collection of damages.

X_____ _____ _____ _____

PATIENT SIGNATURE Date Signature of Authorized Staff Date

ACKNOWLEDGE & AFFIRM:

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.

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**

I authorize NEW AGE MEDICAL CLINIC PA to use automated text / SMS and pre-recorded messages to my cell phone or home phone to confirm appointments and inform me of special discounts and inform me of marketing specials. Standard fees from your cell phone provider apply. I can opt out of such services at any time. SENDING "STOP" to TEXT RECEIVED. NO DIFFERENCE IN SERVICES PROVIDED TO THOSE WHO DON'T SIGN UP FOR TEXTS.

X_____ _____

Patient Signature Date

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**

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**
- **The total costs of HCG Diet program have been discussed.**

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**