Name:____ **Date**: ______/______/______

Address: **Street**____

City____

State:__________ **Zip:**___________________**Cell Phone**: (______)_____________________________

Home Phone: (______)_______________________ **Email**: _____________________________________

HOW DID YOU FIND OUT ABOUT US? (Circle) **: Internet Search | Natural Awakenings Magazine | Signs | Car Sign | fax | referred by _______________________ | business card | other______________________**

Date of Birth: _____/____/_____ **Gender**: M F **Marital Status**: S M D W

Age: _______________ **Height**: ______'_______" **Weight**: ______________ lbs.

Emergency Contact: Name: ____________________________Phone:_______________

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

____

MEDICATIONS: ____

____

MEDICAL AILMENTS *THAT YOU HAVE SEEN A PHYSICIAN FOR:* ____________________________________

____

SYMPTOMS OR COMPLAINTS *YOU CURRENTLY HAVE:*____

____

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
   - ☐ Deep wrinkles
   - ☐ Under eye circles
   - ☐ Sagging skin
   - ☐ Sagging cheek bones
   - ☐ Dark spots
   - ☐ Rough skin texture
   - ☐ Large pores
   - ☐ Scars (acne or surgical)
   - ☐ Stretch marks
   - ☐ None
   - ☐ Other (please describe)____

Please describe your skin type (check ALL that apply)

- ☐ Normal
- ☐ Combination normal-oily
- ☐ Combinations normal-dry
- ☐ Oily
- ☐ Very dry
- ☐ Sensitive
- ☐ Prone to redness
- ☐ Acne prone
- ☐ 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
- ☐ Chemical peeling within past 3 months
- ☐ Permanent make-up or facial tattoos
- ☐ I had none of the above procedures within indicated time frame ____ (Initials)

Please use following space for comments:

____

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. Is it possible you may be pregnant? Yes____ No____

If "Yes" How far along are you or may you be?
____

5. Do you have any infectious diseases? Yes____ No____

If "Yes" Please Identify:
____

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

	Father	Mother	Brothers	Sisters	Children
Age (if living)					
Health (G=Good. P=Poor)					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Mental Illness					
Asthma/Hay Fever/Hives					
Kidney Disease					
Age (At Death)					
Cause Of Death					

7. **(10 years)** Past Max Weight: ___________ Past Min Weight: _____________

8. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____Taken: ___/___/___

HAVE YOU BEEN DIAGNOSED WITH OR HAD ANY OF THE FOLLOWING CONDITIONS:

Please Circle ALL that apply: *CURRENTLY ONLY*

➢ Hepatitis	➢ Spasms/Cramps	➢ Constipation / Diarrhea
➢ Headaches	➢ Hot Flashes	➢ Shortness of Breath
➢ Scoliosis	➢ Tendonitis	➢ Thyroid Dysfunction
➢ Brain Fog	➢ Rash /skin problems	➢ Asthma/Allergies /Hay Fever
➢ Neck Pain	➢ Numbness/Tingling	➢ Diabetes
➢ Fatigue	➢ Arthritis/Stiff/Painful Joints	➢ Dizziness
➢ Back	➢ Sciatica/Shooting pain	➢ Pregnancy
➢ Pain	➢ Osteoporosis	➢ Infection
➢ Fever	➢ Heart Disease	➢ PMS /Menstrual Problems
➢ Shoulder Pain	➢ Bladder/Kidney Disease	➢ High Cholesterol
➢ Night Sweats	➢ Stroke	➢ TMJ or Jaw Pain
➢ Leg Pain	➢ Cancer	➢ Gout
➢ Insomnia	➢ Blood Clots	➢ Anorexia
➢ Heart Murmur	➢ Gas / Bloating	➢ Bulimia
➢ Depression	➢ High Blood Pressure	
➢ Epilepsy / seizures	➢ Abdominal Pain	
	➢ Chest Pain	
	➢ Anxiety	

If yes

*Explain:*____

9. Digestion Issues:

(Circle if yes)

Nausea | Vomiting | Diarrhea | Blood in stool | Pain | Bloating | Gas | ABD Distention | Constipation | Incomplete Evacuation | Small Round Stool | Hard Stool | Significant Residual When Wiping | ABD cramping | other digestive concerns if any____

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 | Pain upon defecation: yes / no | Blood in Stool: yes / no | Hemorrhoids: yes / no |

Last Bowel Movement________________Previous Interventions: None / Laxatives / Enemas / Other______

Frequency of Bowel Movements____________ Color___________ Consistency: (circle all that apply): thin, thick, hard, soft, watery, small round, clay like

10. **Other :**

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

11. **Childhood Illness:** (circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations:** (circle any that you have had):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria HiB Hepatitis-B Chicken Pox

Pneumonia Flu Other____________________

13. **Hospitalizations and Surgeries:**

Reason	When	Reason

14. **X-Rays / CAT Scans / MRIs / NMRs / Special Studies:**

Reason	When	Reason

15. **For the following questions:**
(circle any that you experience now and underline any you have experienced in the past)

16. **Emotional/Psychiatric :**

Mood Swings Nervousness Mental Tension Irritability Depression Grief Obsessive Thinking
issues:____

17. **Energy and Immunity :**

Fatigue Slow Wound Healing Chronic Infections Lyme Disease Chronic Fatigue

Candida / Yeast Infections

18. **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

19. **Respiratory :**

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy

Asthma Tuberculosis Shortness of Breath Other
Respiratory_________________________________

20. **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

21. **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

22. **Genito-Urinary Tract :**
Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

23. **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

24. **Male Reproductive :**

Erectile Dysfunction   Prostrate Problems   Testicular Pain/Swelling   Penile Discharge

25. **Musculoskeletal :**

Neck/Shoulder Pain   Muscle Spasms/Cramps   Arm Pain   Upper Back Pain   Mid Back Pain

Lower Back Pain   Leg Pain   Joint Pain

26. **Neurologic :**

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

27. **Endocrine :**

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

28. **Lifestyle:**

a. Do you typically eat at least three meals per day?   Y   N   If no, why not?___________________________

b. Exercise routine: ____

c. Spiritual Practice: ____

d. How many hours per night do you sleep? ______________   Do you wake rested?   Y   N

e. Level of education completed: High School   Bachelors   Masters   Doctorate   Other

f. Occupation: ______________________________________ Employer: _____________________________

Hours/Week: ______________   Do you enjoy work?   Y   N Why/Why Not?__________________

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

Amount:_________________________________ Frequency:___________________________

h. Alcohol Use (what form):_________________________________ (past or present)

Amount:_________________________________ Frequency:___________________________

i. Recreational Drugs(what form):________________________________ (past or present)

Amount:_______________________________ Frequency:__________________________

j. Have you experienced any major traumas? Y N Explain: _________________________

____

k. How many 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?____

Family Physician____

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;
4) All supplied 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 can 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.

X ____ _______________
Patient Signature Date

X ____ _______________
Signature of Health Care Provider Date

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 obtained from me or unless 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.

Signature of Patient ……………………………………………….Date: ………………

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 ………………………………………………. Date: ………………

MEDICARE PRIVATE CONTRACT (page 1 of 2)

ALL CLIENTS 64 & Older *MUST SIGN THIS*

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.

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 on _____________(Today's Date) 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, have caused this agreement to be executed on the date written below.

NEW AGE MEDICAL CLINIC PA

_____________________________________ ____________
Signature of Staff Date

____
Name of Patient (printed)

____ _______________
Signature Date

HCG DIET PATIENTS COMPLETE

HCG DIET PATIENTS ONLY

I _________________________________(patient name) acknowledge and understand that Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA 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. NEW AGE MEDICAL CLINIC PA 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 NEW AGE MEDICAL CLINIC PA is not responsible for my individual performance or my ability to adhere to the diet. There are NO guarantees for individual weight loss.

In fact, I acknowledge that I have done my own research and am requesting that the NEW AGE MEDICAL CLINIC PA provide the HCG Diet to me.

I agree that ONCE I START THE DIET IT LASTS FOR ONLY 25 or 40 Days 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 25 or 40 DAY PERIOD FOR WHICH I SIGNED UP IS OVER.

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 Maria Romanenko, D.O. or NEW AGE MEDICAL CLINIC PA

I UNDERSTAND THERE ARE NO REFUNDS OR PARTIAL CREDITS.

X ____ __________

Signature **Date**

CONTRINDICATIONS or CONCERNS requiring more information prior to prescribing HCG Diet:

DO YOU HAVE or HAVE A 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

X ____ __________

Signature **Date**

HCG DIET PATIENTS ONLY

HCG DIET PATIENTS COMPLETE **Informed Consent HCG Diet**

Patient Name_________________________________ **Age**____________ **Date**____________

NEW AGE MEDICAL CLINIC PA 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 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 are 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 take precautionary measures with birth control during the time frame while on HCG Diet. X_______________.

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**
- 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.* 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 | Date | NEW AGE MEDICAL CLINIC PA Provider