

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: Past or Present.

<ul style="list-style-type: none"> ➤ Hepatitis ➤ Headaches ➤ Scoliosis ➤ Brain Fog ➤ Neck Pain ➤ Fatigue ➤ Back ➤ Pain ➤ Fever ➤ Shoulder Pain ➤ Night Sweats ➤ Leg Pain ➤ Insomnia ➤ Heart Murmur ➤ Depression ➤ Epilepsy / seizures 	<ul style="list-style-type: none"> ➤ Spasms/Cramps ➤ Hot Flashes ➤ Tendonitis ➤ Rash /skin problems ➤ Numbness/Tingling ➤ Arthritis/Stiff/Painful Joints ➤ Sciatica/Shooting pain ➤ Osteoporosis ➤ Heart Disease ➤ Bladder/Kidney Disease ➤ Stroke ➤ Cancer ➤ Blood Clots ➤ Gas / Bloating ➤ High Blood Pressure ➤ Abdominal Pain ➤ Chest Pain ➤ Anxiety 	<ul style="list-style-type: none"> ➤ Constipation / Diarrhea ➤ Shortness of Breath ➤ Thyroid Dysfunction ➤ Asthma/Allergies /Hay Fever ➤ Diabetes ➤ Dizziness ➤ Pregnancy ➤ Infection ➤ PMS /Menstrual Problems ➤ High Cholesterol ➤ TMJ or Jaw Pain ➤ Gout ➤ Anorexia ➤ Bulimia
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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:

<u>Reason</u>	<u>When</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Reason</u>	<u>When</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____

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.
- 9) I consent to live encrypted audio & video monitoring 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.

X _____
Patient Signature

Date

X _____
Signature of Health Care Provider

Date

PLEASE CIRCLE ALL CONDITIONS YOU CURRENTLY HAVE

COMMON ICD-9 CODES**Alphabetical Listing**

789.07	Abdominal pain, generalized	042	Human immunodeficiency virus (HIV) disease
789.00	Abdominal pain, unspecified site	276.8	Hypokalemia
790.6	Abnormal blood chemistry, other	272.0	Hypercholesterolemia, pure
796.4	Abnormal clinical findings, other	272.1	Hyperglyceridemia, pure
995.2	Adverse effect of drug, unspec, medicinal and biological substa	272.2	Hyperlipidemia, mixed
496	Airway obstruction, chronic, not elsewhere classified (COPD)	272.4	Hyperlipidemia, other & unspecified
477.9	Allergic rhinitis, cause unspecified	401.1	Hypertension, essential, benign
331	Alzheimers	401.0	Hypertension, essential, malignant
280.9	Anemia, iron deficiency, unspecified	401.9	Hypertension, essential, unspecified
281.0	Anemia, pernicious	402.10	Hypertensive heart disease, benign, w/o CHF
285.9	Anemia, unspecified	402.90	Hypertensive heart disease, unspec. w/o CHF
413.9	Angina pectoris, other & unspecified	276.8	Hypopotassemia
300.00	Anxiety state, unspecified	244.9	Hypothyroidism, unspecified
424.1	Aortic valve disorders	564.1	Irritable bowel syndrome
716.99	Arthropathy, unspecified, multiple sites	280.1	Iron def. Anemia, Secondary to low dietary iron intake
493.90	Asthma, unspecified, w/o mention of status asthmaticus	414.9	Ischemic heart disease, chronic, unspecified
427.31	Atrial fibrillation	585.9	Kidney Disease, Chronic
266.2	B12/Folate deficiency	593.9	Kidney & ureter disorder, unspecified
466.0	Bronchitis, acute	623.5	Leukorrhea, not specified as infective
427.9	Cardiac dysrhythmia, unspecified	272.9	Lipoid metabolism disorder, unspecified
425.4	Cardiomyopathies, primary, other	573.9	Liver disorder, unspecified
429.2	Cardiovascular disease, unspecified (ASCVD)	794.8	Liver function studies, nonspecific abnormal results
436	Cerebro vascular disease,acute but ill defined (CVA, stroke)	V58.61	Long term use of anticoagulants
616.0	Cervicitis & endocervicitis	V58.69	Long-term(current)use of other meds, eg, highrisk meds
786.51	Chest pain over heart and lower thorax	724.2	Lower back pain (Lumbago)
286.9	Coagulation defects, other & unspecified	263.1	Malnutrition of mild degree
298.2	Confusion	627.2	Menopausal or female climacteric states
428.0	Congestive heart failure	424.0	Mitral valve disorders
564.00	Constipation, unspecified	729.1	Myalgia & myositis, unspecified
780.31	Convulsions, febrile	238.2	Neoplasm of uncertain behavior, skin
780.39	Convulsions, other	216.5	Neoplasm, benign, skin of trunk except scrotum
414.01	Coronary atherosclerosis of native coronary artery	174.9	Neoplasm, malignant, female breast, unspecified
414.00	Coronary atherosclerosis,unspecified type vessel,native or graft	185	Neoplasm, malignant, prostate
786.2	Cough	715.09	Osteoarthritis, generalized, multiple sites
595.9	Cystitis, acute	733.01	Osteoporosis, Senile (Postmenopausal)
311	Depressive disorder, not elsewhere classified	785.1	Palpitations
250.01	Diabetes, type I (IDDM), not stated as uncontrolled	577.0	Pancreatitis, acute
250.00	Diabetes, type II (NIDDM) or unspecified type, controlled	443.9	Peripheral vascular disease, unspecified
250.02	Diabetes, type II (NIDDM) or unspecified type, uncontrolled	486	Pneumonia, organism unspecified
250.90	Diabetes type II (NIDDM) w/complications	790.93	Prostate specific antigen (PSA) elevation
787.91	Diarrhea	600.00	Prostatic hypertrophy (benign) w/o urinary obstruct.
780.4	Dizziness & giddiness	601.0	Prostatitis, acute
786.09	Dyspnea & respiratory abnormalities, other	586	Renal Failure, unspecified
788.1	Dysuria	714.0	Rheumatoid arthritis
782.3	Edema	295.90	Schizophrenia, unspecified
276.9	Electrolyte and fluid disorders not elsewhere classified	461.9	Sinusitis, acute, unspecified
796.2	Elevated blood pressure w/o diagnosis of hypertension	686.9	Skin infection, local, unspecified
790.4	Elevation of LDH, nonspecified	473.9	sinusitis, chronic, unspecified
259.9	Endocrine disorder, unspecified	462	Sore Throat
345.90	Epilepsy, unspecified, w/o mention of intractable epilepsy	780.2	Syncope & collapse
530.81	Esophageal reflux	781.7	Tetany
780.79	Fatigue/Malaise, other	246.9	Thyroid disorder, unspecified
780.60	Fever	435.9	Transient cerebral ischemia, unspecified
558.9	Gastroenteritis and colitis, noninfectious, unspecified	465.9	Upper respiratory infection, acute, unspecified site
530.81	Gastroesophageal Reflux Diseases (GERD)	788.69	Urinary abnormality, other
274.9	Gout, unspecified	788.41	Urinary frequency
784.0	Headache	788.39	Urinary incontinence, other
428.9	Heart failure, unspecified	788.20	Urinary retention, unspecified
599.7	Hematuria	599.60	Urinary Obstruction, other
569.3	Hemorrhage of rectum & anus	599.0	Urinary Tract Infection, site not specified
286.5	Hemorrhagic disorder due to circulating anticoagulant	783.1	Weight gain, abnormal
573.3	Hepatitis, unspecified	783.21	Weight loss, abnormal

Signature

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 PatientDate:

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

Informed Consent IV Vitamins, IV Vitamin C & IV minerals

Print Patient Name _____ Age _____ Date _____

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

Patient agrees to consult with primary care physicians as to the safety and efficacy of the treatments provided by staff at New Age Medical Clinic PA / Dr. Maria Romanenko, DO given their familiarity with patient’s underlying medical history and response to medications received.

Patient understands that the treatments provided by staff at New Age Medical Clinic PA / Dr. Maria Romanenko, DO are experimental in nature as there is not significant peer reviewed medical literature supporting the use of such therapies.

Patient acknowledges that I have not been pressured to make any decision and have had the opportunity to discuss all treatments proposed with my primary care physician and given the opportunity to ask questions.

Patient has made an informed decision based on all the information provided by the New Age Medical Clinic PA / Dr. Maria Romanenko, DO & Staff and with consultation with primary care physician and has had the opportunity to review any peer reviewed scientific journals that may have reported on the therapies proposed. Such journals can be reviewed for free at UMDNJ Library 30 12th Ave. Newark NJ, 07101, Phone: 973-972-4580 or accessed by subscribing online at <http://www.questia.com>.

I understand that IV Vitamin C therapy is considered controversial for the generalized treatment of cancer, viruses and other degenerative diseases, and a minority of the medical community accepts the view that it is of benefit in the treatment of such disorders. Opponents consider such use of IV Vitamin C therapy to be “experimental.” New Age Medical strongly opposes me utilizing such treatments in place of traditional treatments.

WOMEN of Child Bearing Years:

I certify that there is NO possible way that I could be pregnant X_____ (women in child bearing years must receive pregnancy test if they have had sexual intercourse since last menstrual period unless they have had a hysterectomy.)

I agree that I will either refrain from sexual intercourse during heavy metal detoxification and for 60 days since last treatment or take precautionary measures with birth control during this time frame. X_____

Treatments may cause the side effects listed below as well as others. 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.

Side effects / Potential risks:

Inflammation of a vein:

If an infusion into a vein is performed too rapidly, inflammation may occur. X_____ (patient initials)

Infection is possible if patient has immune compromise or by unexplained introduction of pathogen or existing infection in patient worsening. X_____ (patient initials)

If you have history of Congestive heart failure or uncontrolled hypertension:

If the heart is already unable to cope adequately with the movement of fluids or there is evidence of congestive heart failure (extreme shortness of breath, swollen ankles) patient should avoid excess fluids as it could increase the fluid retention tendency. I certify I have NOT been diagnosed with congestive heart failure X_____ (patient initials)

The patient’s diagnosis, if known: trace amounts of heavy metals | atherosclerosis | claudication | preventive medicine | high blood pressure | diabetes | (other)_____

Patient acknowledges that they were informed WE DO NOT CLAIM TO CURE ANY DISEASE X _____(patient initials)

The nature and purpose of a proposed treatment or procedure: IV vitamins, IV mineral, and IV antioxidant (glutathione) supplements.

The possible but NO DEFINITE benefits of a proposed treatment or procedure: not certain | possible reversal of disease | prevention of disease | improved general wellbeing.

- **Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance):** healthy eating | surgery | do nothing | consult experts | Radiation | Chemotherapy | _____
- **The risks of not receiving or undergoing a treatment or procedure:** stay the same | get worse | possibly none
- **The benefits of not receiving or undergoing a treatment or procedure:** save money | condition may resolve itself

X _____(Patient Signature)

X _____
Healthcare Provider