NEW AGE MEDICAL CLINIC PA INTAKE EVALUATION (973) 803-2643

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) _____

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____
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: _____

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 ____
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 ____ |

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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")

I _____(hereafter "PATIENT") certify that I am a BONIFIED Patient of DR. Maria Romanenko, DO/ New Age Medical Clinic PA (hereafter "Medical Clinic")and that any ill intention or action taken by me that creates a financial harm, potential harm to reputation or hinders business practices or fosters the development of a competing medical practice of Medical Clinic shall be deemed detrimental to the business. PATIENT seeks to benefit from the services provided by Medical Clinic seeks to benefit from fees charged to PATIENT. In the event that it is discovered that PATIENT is not a BONIFIED patient and that PATIENT's motivation for engaging the time, efforts and expertise of the staff of Medical Clinic was to promote a competing business venture or to bring about any action or publicity that might cause financial harm to Medical Clinic its shareholders or employees; PATIENT agrees to be personally liable (even if working on behalf of another party) for all financial costs, opportunity costs, employee hourly fees and legal fees for collection of damages. Furthermore, PATIENT and Medical Clinic agree that all disputes will be settled by binding arbitration through American Arbitration Association (AAA). However, as necessitated by the fact that delays might occur in obtaining injunctive relief in Arbitration and continued disclosures by PATIENT will irreparably harm the business of Medical Clinic both PATIENT and Medical Clinic agree to the exception that New Jersey Superior Court of Essex, Bergen or Monmouth County (or court of competent jurisdiction) and is hereby authorized by both PATIENT and Medical Clinic to grant injunctive relief (Temporary Restraining Order) without necessity of posting a bond until such time as a board of Arbitration can be convened to decide the case, both parties agree that utilizing American Arbitration Association (AAA) to grand injunctive relief or decide the case will cause irreparable harm to Medical Clinic Additionally, both Patient and Medical Clinic agree that Medical Clinic is permitted at any point to seek any type of provisional/interim relief from American Arbitration Association (AAA); as neither party has chosen to waive the ability of an arbitrator to provide provisional remedies, including interim relief without necessity of posting a bond. Both parties acknowledge the have had ample opportunity to have legal counsel review this agreement and are not being coerced in any way to sign this agreement.

X_____ _____ _____ _____

Patient Signature Date **For** New Age Medical Clinic PA Date

NEW AGE MEDICAL CLINIC PA INTAKE EVALUATION (973) 803-2643

I _____(patient name) acknowledge and understand that:

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

X_____ _____

Patient Signature Staff Signature

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

PRIMARY CARE PHYSICIAN: _____Address: _____

_____(fax) _____

Patient Name: _____ SS# _____

Date of Birth: ____/___/_____ TODAY'S DATE: ____/___/_____ X(signature) **X** _____
(signature)

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

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

PURPOSE: **Continued Medical Care**

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

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

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

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_____ _____

Signature of Patient Signature of Staff

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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:

_____

_____

PATIENT Signature X _____ **STAFF Signature** _____

HCG DIET CERTIFICATION:

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 7, 14, 21, 28, 42 or 56 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 7, 14, 21, 28, 42 or 56 DAY PERIOD FOR WHICH I SIGNED UP REACHES 7, 14, 21, 28, 42 or 56 days 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.

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.

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

PATIENT Signature	**STAFF Signature**
X	

HCG DIET Informed Consent

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

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

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

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

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

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

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

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

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

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

X_____ _____

PATIENT Signature **STAFF Signature**

INFORMED CONSENT B12 / MIC Lipotropic Shots

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I have been informed of the following:

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

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

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

Patient Signature **X** _____ Date_____ Staff_____

(SERMORELIN page 1) Sermorelin Acetate (Growth Hormone Releasing Hormone /Peptide) Therapy

INFORMED CONSENT FOR GROWTH HORMONE PEPTIDES & HORMONES TREATMENT AND RELEASE AGREEMENT

I_____ hereby consent to be evaluated and treated by Dr. Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA with the objective of preventive medicine and improvement in existing medical symptoms and no guarantees can be made that such treatments will improve existing medical conditions. The recommended treatments and therapies may include nutritional guidance, administration of neutraceuticals (a combination of nutrient and pharmaceutical), and hormone replacement therapy for hormone deficiencies. I understand the treatment regimen will likely involve the administration of neutraceuticals and hormones, including growth hormone releasing hormones and peptides. I understand that Dr. Maria Romanenko, D.O. may be assisted by other healthcare professionals, as necessary, and agree to their participation in my care as it relates to neutraceuticals, nutrition, and hormone replacement therapy. I make this decision to participate in this treatment without any pressure from Dr. Maria Romanenko, D.O. or NEW AGE MEDICAL CLINIC PA staff. Initial **X**_____

Reactions to Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy
As is the case with the administration of any Hormone Replacement Therapy, systemic or local allergic responses can sometimes result. It is vital that patient (and parent if applicable) be aware that such responses can potentially occur. If the patient suffers an allergic reaction as a result of **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy** it is vital that they receive medical attention promptly.
Initial **X** ____

Clinical Tests have shown that increased blood-serum levels of Insulin-Like Growth Factor One (IGF-1), Human Growth Hormone, alkaline phosphatase, and inorganic mineral phosphorus can occur as a result of **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy**. Initial **X** ____

Drug Interactions
Taking glucocorticoid steroids in combination with **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy** maybe reduce the effectiveness of Therapy. In clinical studies of **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy** no evidence has been discovered, it is still important to note that their have been no clinical studies regarding formal medical interactions. Initial **X** ____

Fertility Impairment, Mutagenesis, Cancer risk
There has been no longitudinal animal research regarding fertility impairment or carcinogenicity risk regarding **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy**. There has been absolutely no clinical research linking **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy** to genetic abnormalities. Initial **X** ____

Pregnancy
There has been some animal research conducted regarding **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy**. At a dosage somewhere between three and six times the normal daily dosage that a human patient receives adjusted for physical surface area, minor fetal changes occurred in rabbits and rats. There have been no adequately controlled studies regarding the usage of **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy** by women who are pregnant. G **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy** should NOT be administered to women that are pregnant. I certify there is no way I can be pregnant. Initial **X** _____

Nursing Women
It is unknown if **Sermorelin Acetate / Growth Hormone Releasing Peptide** is produced in human milk. There are many medications that are released by the mother in the nursing process, and for this reason mothers and physicians should exercise caution when using **Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy** while nursing.

Disposal Information
If the physician approves home usage, the patient should use SHARPS containers meant for the proper disposal of used needles and syringes accumulated as a result of Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy. These containers are puncture resistant and are a necessary safety measure to protect both patient and anyone who may come in contact with the used needles and

syringes. It is vital that patient (and parent, if applicable) be directed thoroughly as to the vital important of proper needle disposal. Also, they should be informed of the dangers of reusing syringes and needles as well.

Side Effects

A significant portion of Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy patients develop antibodies against Growth Hormone Factor during at least one point of therapy. There is no clear assessment of the significance of the presence of these antibodies, and the levels of these antibodies can change quickly from test to test. A positive result at one juncture regularly turns into a negative result after the next test. The production of these antibodies does not seem to have any adverse effect on the patient. Also, these antibodies do not seem to produce any change in the effectiveness of Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy. There have been no reported general allergic responses to Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy.

The most common reaction to Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy which is related to treatment is local irritation around the injection site, which occurs in around one of every six patients. This irritation is characterized by redness, pain, or swelling. Though this side effect is relatively common, only a small minority of patients find the irritation bothersome enough to suspend therapy. Out of a sample of 350 patients who underwent Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy in clinical trial, only three suspended therapy as a result of injection-site irritation. There are other side effects which occurred in less than one percent of patients. These side effects include: severe drowsiness, hives, vomiting, headache, nausea, difficulty swallowing, hyperactivity, chest tightness and pallor, distortion in perception of taste, and flushing of the skin.

Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy Dependency and Abuse

There is no evidence to suggest that the use of Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy for any period of time will result in any sort of dependency or proclivity toward abuse. The general pharmacology of Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy does not produce any addictive effect, and clinical trials have produced no evidence of such an effect.

Never Take More than Prescribed

It is not recommended to exceed the recommended dosage of Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy prescribed by your physician. Overdose will not provide better results. It will only increase the occurrence of side effects.
Initial **X** _____

Hormone Therapy

While hormones can be administered by applying creams to the skin, I understand that some hormone therapies (typically require one subcutaneous injections (that is syringe injections - “shots” under the first few layers of skin) per day. I understand there are certain risks associated with this procedure. The risks include; (1) water retention which may result in leg swelling; (2) elevated blood pressure, which may be reversed with dose adjustment; (3) an initial mild increase in fasting blood sugar (if I am diabetic); (4) bruises at the injection site; and (5) infection at the injection site if improper techniques are used. By agreeing to undergo this therapy I accept these risks and freely agree to participate in this type of hormone therapy.

I understand the possible benefits of hormone therapy can include: controlling or stopping menopause or andropause symptoms; improving my physical and mental shape; increased energy; decreased wrinkles; losing weight; an improved sex life; and sleeping more soundly. Also, I have been counseled by Dr. Maria Romanenko, D.O. and other staff of NEW AGE MEDICAL CLINIC PA about hormone therapy.

Human Growth Hormone can affect cell metabolism and cell growth. For example, if a patient had an underlying and/or undetected cancerous growth prior to undergoing hormone therapy, the administration Sermorelin or other hormones could possibly induce further growth of the underlying cancer. Some studies contradict this theory but results are unknown. Initial **X** ____

All questions I had regarding hormone replacement therapy have been answered to my satisfaction. I understand that I will be responsible for injecting and administering any hormones prescribed to me. I agree to conform and comply with the recommended doses and methods of administration. I also agree to comply with requests for initial and subsequent blood tests, as required, to monitor my hormone levels.
Initial **X** _____

Off-Label Use of FDA-Approved Drugs
I also understand that hormone replacement therapy may include the "off-label" use of FDA-approved drugs. "Off-label use" means an FDA-approved drug is used in therapies and treatments for which the drug was not specifically approved. As much as forty-six per cent (46%) of certain classes of prescriptions are for off-label use of FDA-approved drugs. The reasonable alternatives to hormone replacement therapy have been explained to me and they include: (1) leaving the hormone levels as they are; and (2) treating diseases as they appear.
Initial **X** ____

Informed Consent
I understand that no guarantee has been made to me regarding the outcome of the Neutraceutical, Antioxitant, or Hormone therapies. I also understand that the benefits derived from these therapies will stop if the therapies are discontinued.

In addition, I assume full liability for any adverse effect that may result from the non-negligent prescribing of the Neutraceuticals, Antioxitants, Hormones, Drugs, or other treatments involved in the therapies and medical care prescribed or recommended by Dr. Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA, and I release her from any and all claims (legal or otherwise), grievances, or damages (monetary or otherwise) arising from my treatment as her patient.

I hereby confirm and attest that I am not under the jurisdiction of any governing body with prohibits the use of hormone and/or human growth hormone replacement therapy, such as sports organizations, competitive athletic/bodybuilding organizations, Olympic sports teams, or the like. Initial **X** ____

I certify that I am under the care of another physician or physicians for all other medical conditions. I will consult with this or these physician(s) for any other medical services I may require. I understand that Dr. Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA 's practice is specialized and that she is NOT my primary care physician. I agree that I will continue under the active care of my other physician(s) for any medical condition and medical consultations that I may need. I understand that this clinic will not prepare insurance claim forms for me. Initial **X** ____

I hereby understand, agree, and confirm that the therapies and treatments recommended by Dr. Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA are elective. The risks involved and the possibilities of complications have been explained to me. I understand that any prescribed therapies and treatments are based on the medical judgment of Dr. Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA based on her expertise in this field of medicine. I understand that I may suspend or terminate treatment at any time, and I hereby agree to immediately notify Dr. Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA of any such suspension or termination. To attest to my consent to this treatment regimen and the releases stated above, I hereby sign this authorization for treatment.

I have spoken to my primary care physician regarding Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy and he/she has no objections to my starting the program.

I acknowledge that there are no guarantees relating to the effectiveness of Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy and that I have done my own research and have made a well informed decision to start the treatment and agree that NEW AGE MEDICAL CLINIC PA and staff are not responsible for my individual performance or my ability to adhere to the program. There are NO guarantees and there are NO REFUNDS.

In fact, I acknowledge that I have done my own research and am requesting that the NEW AGE MEDICAL CLINIC PA provide Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy to me.

I am certain I'll be ready to start Sermorelin Acetate / Growth Hormone Releasing Peptide Therapy when I start it. I acknowledge that any medical ailments or personal issues preventing adherence to complete the therapy is not the fault or responsibility of Maria Romanenko, D.O. or NEW AGE MEDICAL CLINIC PA

Risks: INFECTION, ANTIBODY PRODUCTION (REDNESS AND SWELLING IN AREA OF INJECTION) ADDITIONAL UNKNOWN RISKS

(SERMORELIN page 4)

Benefits of short- and long-term treatment: IMPROVED OVERALL HEALTH

Less-intrusive alternatives: EXERCISE & IMPROVED NUTRITION

The consequences of the cessation of treatment: NO KNOWN CONSEQUENCES OF DISCONTINUING TREATMENT

Financial costs associated with treatment: Sermorelin $550 first month / Sermorelin with GHRP-2 & GHRP-6 $650 per month

Blood work required: Men: CBC, BMP, IGF-1, PSA / Women: CBC, BMP, IGF-1, PREGNANCY

Followup Required: Monthly office visits with physical exam and interview of experience

Conditions We Treat With Sermorelin Acetate (Growth Hormone Releasing Hormone and Peptides):

Negative changes in memory, processing speed and attention, Lack of well-being, Depression, Anxiety, Social isolation, Fatigue, Lack of strength, Fibromyalgia syndrome, Neuromuscular dysfunction, Central adiposity (increased fat around abdomen), Decreased muscle mass, Decreased bone density, Impaired cardiac function, Decreased insulin sensitivity (elevated blood sugar) Increased low-density lipoprotein (bad cholesterol), Prothrombotic state (easily develop clots), Decreased sweating and thermoregulation (feeling hot / cold).

We do not prescribe, order, dispense, administer, sell, or transfer sermorelin or GHRP-2 to any person for the purpose of hormonal manipulation intended to increase muscle mass, strength, stamina, or weight; nor for use for body building, muscle enhancement, or increasing muscle bulk or strength by a person in good health for the intended purpose of improving performance in any form of exercise, sport, or game.

PLEASE CIRCLE YES OR NO

a. **YES OR NO** Negative changes in memory, processing speed and attention
b. **YES OR NO** Lack of well-being
c. **YES OR NO** Depression
d. **YES OR NO** Anxiety
e. **YES OR NO** Social isolation
f. **YES OR NO** Fatigue
g. **YES OR NO** Lack of strength
h. **YES OR NO** Fibromyalgia syndrome
i. **YES OR NO** Neuromuscular dysfunction
j. **YES OR NO** Central adiposity (increased fat around abdomen)
k. **YES OR NO** Decreased muscle mass
l. **YES OR NO** Decreased bone density
m. **YES OR NO** Impaired cardiac function
n. **YES OR NO** Decreased insulin sensitivity (elevated blood sugar)
o. **YES OR NO** Increased low-density lipoprotein (bad cholesterol)
p. **YES OR NO** Prothrombotic state (easily develop clots)
q. **YES OR NO** Decreased sweating and thermoregulation (feeling hot / cold).

_____
Print Patient Name

X _____ _____
Patient Signature Date Witness/ Staff Member

NEW AGE MEDICAL CLINIC PA INTAKE EVALUATION (973) 803-2643

Patient Name_____ **Age**_____ **Date**_____

COLONIC PATIENTS ONLY

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

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

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

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

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

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

DO YOU HAVE or HAVE YOU EVER BEEN DIAGNOSED WITH:

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

X_____ _____ X _____ _____

Patient Signature Date Staff Witness Date