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.*

➢ 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

PLEASE CIRCLE ALL CONDITIONS YOU CURRENTLY HAVE

COMMON ICD-9 CODES

Alphabetical Listing

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

HCG DIET PATIENTS COMPLETE

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 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

COLONIC PATIENTS COMPLETE

Patient Name_____ Age_____ Date_____

NEW AGE MEDICAL CLINIC PA does NOT treat diseases and any services performed by staff, 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 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.

- 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
- The benefits of a proposed treatment or procedure: Relief
- 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
- ***severe hemorrhoids*** 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 Signature of Healthcare Provider Date

INFORMED CONSENT – CHEMICAL SKIN PEELS, BOTOX, INJECTABLE FILLERS, AND OTHER MEDICAL AESTHETIC SKIN TREATMENTS

INSTRUCTIONS

This is an informed-consent document that has been prepared to help inform you about laser, E-Two (Sublime,& Sublative) chemical skin peel, botox, fillers and other skin treatment procedure(s), its risks, and alternative treatment.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for treatment as proposed by your doctor and agreed upon by you.

GENERAL INFORMATION

Chemical skin peels and other cosmetic skin treatments have been performed for many years to treat a variety of skin disorders. Conditions such as sun damage, wrinkling, and uneven pigmentation may be treated with these noninvasive techniques. There are many different techniques and regimens for the application of chemical-peeling and skin treatment medications. In some situations, chemical peels may be performed at the time of other surgical procedures.

Chemical skin peels and other cosmetic skin treatment procedures are not an alternative to surgical skin tightening treatment when indicated.

ALTERNATIVE TREATMENTS

Alternative forms of management include not treating the skin with chemical-peeling agents or other cosmetic procedures. Improvement of skin lesions and skin wrinkles may be accomplished by other treatments such as dermabrasion, laser treatment, or surgical treatment to tighten loose skin. Risks and potential complications are associated with alternative forms of treatment.

RISKS OF BOTOX, FILLERS, LASER, E-TWO (SUBLIME/SUBLATIVE), CHEMICAL SKIN PEELS / SKIN TREATMENTS

Every procedure involves a certain amount of risk and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual's choice to undergo a procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your doctor to make sure you understand all possible consequences of chemical skin-peeling and other cosmetic skin treatment.

Infection: Although infection following chemical skin peels is unusual, bacterial, fungal, and viral infections can occur. Initial____

Herpes simplex virus infections around the mouth can occur /reoccur following a chemical peel. This applies to both individuals with a history of Herpes simplex virus infections and individuals with no known history of Herpes simplex virus infections in the mouth area. Specific medications must be prescribed and taken both prior to and following the procedure in order to suppress an infection from this virus. Should an infection occur, additional treatment including antibiotics, hospitalization, or additional treatment may be necessary. It is important to tell your Doctor of any other infections, such as ingrown toenail, insect bite, or urinary tract infection. Remote infections, infections in other parts of the body, may lead to an infection in the operated area. Initial____

Scarring: Although good wound healing after a procedure is expected, abnormal scars may occur within the skin and deeper tissues. In rare cases, keloid scars may result. Scars may be unattractive and of different color than the surrounding skin tone. Scar appearance may also vary within the same scar. Scars may be asymmetrical (appear different on the right and left side of the body). In some cases scars may require surgical revision or treatment. Initial____

Color Change: Chemical-peeling agents can permanently lighten the natural color of your skin. There is the possibility of irregular color variations within the skin including areas that are both lighter and darker. Permanent darkening of skin has occurred after chemical peels. A line of demarcation between normal skin and skin treated with chemical peeling agent can occur. Redness after a chemical peel may persist for unacceptably long periods of time. Initial____

Allergic Reactions: In rare cases, allergies have been reported to drugs and agents used for chemical-peeling or skin treatments, tape, suture materials and glues, blood products, topical preparations, and preservatives used in cosmetics. Serious systemic reactions including shock (anaphylaxis) may occur to drugs used during treatment and prescription medications. Allergic reactions may require additional treatment. Initial____

Lack of Permanent Results: Chemical peel or other skin treatments may not completely improve or prevent future skin disorders, lesions, or wrinkles. No technique can reverse the signs of skin aging. Additional surgical procedures may be necessary to further tighten loose skin. You may be required to continue with a skin care maintenance program after a chemical-peel procedure. Initial____

Skin Discoloration / Swelling: Some swelling normally occurs following a chemical skin peel. The skin in or near the procedure site can appear either lighter or darker than surrounding skin. Although uncommon, swelling and skin discoloration may persist for long periods and, in rare situations, may be permanent. Initial____

Skin Sensitivity: Itching, tenderness, or exaggerated responses to hot or cold temperatures may occur. Usually this resolves during healing, but in rare situations it may be chronic. Initial____

Damaged Skin: Skin that has been previously treated with chemical peels or dermabrasion, or damaged by burns, electrolysis (hair removal treatments), or radiation therapy may heal abnormally or slowly following treatment by lasers or other surgical techniques. The occurrence of this is not predictable. Additional treatment may be necessary. If you have ever had such treatments, you should inform your surgeon. Initial____

Topical Anesthesia: Both local and topical anesthesia involve risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia and sedation. Initial____

Pain: You will experience pain after your treatment. Pain of varying intensity and duration may occur and persist after treatment. Very infrequently, chronic pain may occur after chemical peel and other cosmetic procedures. Initial____

Unknown Risks: There is the possibility that additional risk factors of chemical skin peels and other cosmetic skin treatments may be discovered. Initial____

ADDITIONAL ADVISORIES

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray): Patients who are currently smoking or use tobacco or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying, delayed healing and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication.

Please indicate your current status regarding these items below :

Initial Just ONE:

I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing cosmetic procedure complications.

____ I am a smoker or use tobacco / nicotine products. I understand the risk of cosmetic procedure complications due to smoking or use of nicotine products.

____ I have smoked and stopped approximately _____ ago. I understand I may still have the effects and therefore risks from smoking in my system, if not enough time has lapsed. It is important to refrain from smoking at least 6 weeks before treatment and until your physician states it is safe to return, if desired. I acknowledge that I will inform my physician if I continue to smoke within this time frame, and understand that for my safety, the treatment, if possible, may be delayed.

Off-Label FDA Issues:
There are many devices, medications and injectable fillers and botulinum toxins that are approved for specific use by the FDA, but this proposed use is “Off-Label”, that is not specifically approved by the FDA. It is important that you understand this proposed use is not experimental and your physician believe it to be safe and effective. Examples of commonly accepted “Off-Label” use of drugs or devices include the use of aspirin for prevention of heart disease, retinoids for skin care, and injection of botulinum toxin for wrinkles on the forehead. I acknowledge that I have been informed about the Off-Label FDA status of all medications used in treatment. and I understand it is not experimental and accept its use. Initial____

Medications and Herbal Dietary Supplements: There are potential adverse reactions that occur as the result of taking over-the-counter, herbal, and/or prescription medications. Aspirin and medications that contain aspirin interfere with clotting and can cause more bleeding. These include non-steroidal anti-inflammatories such as Motrin, Advil, and Alleve. It is very important not to stop drugs that interfere with platelets, such as Plavix, which is used after a stent. It is important if you have had a stent and are taking Plavix that you inform the doctor. Stopping Plavix may result in a heart attack, stroke and even death. Be sure to check with your physician about any drug interactions that may exist with medications which you are already taking. If you have an adverse reaction, stop the drugs immediately and call your doctor for further instructions. If the reaction is severe, go immediately to the nearest emergency room. Be sure to take your prescribed medication only as directed. Initial____

Sun Exposure – Direct or Tanning Salon: The effects of the sun are damaging to the skin. Exposing the treated areas to sun may result in increased scarring, color changes, and poor healing. Patients who tan, either outdoors or in a salon, should inform their doctor and either delay treatment, or

avoid tanning until the doctor says it is safe to resume. The damaging effect of sun exposure occurs even with the use sun block or clothing coverage. Initial____

Travel Plans: Any treatment holds the risk of complications that may delay healing and delay your return to normal life. Please let the doctor know of any travel plans, important commitments already scheduled or planned, or time demands that are important to you, so that appropriate timing of treatment can occur. There are no guarantees that you will be able to resume all activities in the desired time frame. Initial____

Long-Term Results: Subsequent alterations in appearance may occur as the result of aging, weight loss or gain, sun exposure, pregnancy, menopause, or other circumstances not related to skin treatments. Skin peels and other medical cosmetic procedures do not arrest the aging process or produce permanent tightening of the skin. Future treatment or other treatments may be necessary to maintain you results. Initial____

Skin Lesion Recurrence: Skin lesions can recur after a chemical peel or any cosmetic skin treatments. Additional treatment or secondary treatment may be necessary. Initial____

Skin Cancer / Skin Disorders: Skin peels and other cosmetic skin treatment procedures do not offer protection against developing skin cancer or skin disorders in the future. Initial____

Female Patient Information: It is important to inform your doctor if you use birth control pills, estrogen replacement, or if you suspect you may be pregnant. Many medications including antibiotics may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. Initial____

Mental Health Disorders and Elective Treatment: It is important that all patients seeking to undergo elective treatment have realistic expectations that focus on improvement rather than perfection. Complications or less than satisfactory results are sometimes unavoidable, may require additional treatment and often are stressful. Please openly discuss with your surgeon, prior to treatment, any history that you may have of significant emotional depression or mental health disorders. Although many individuals may benefit psychologically from the results of elective treatment, effects on mental health cannot be accurately predicted. Initial____

ADDITIONAL TREATMENT OR TREATMENT NECESSARY

There are many variable conditions which influence the long term result of chemical skin-peeling and other cosmetic skin treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with these procedures. Other complications and risks can occur but are even more uncommon. Should complications occur, additional treatment or other treatments may be necessary. The practice of medicine and treatment is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained. Initial____

PATIENT COMPLIANCE

Follow all physician instructions carefully; this is essential for the success of your outcome. Post-procedure instructions concerning appropriate restriction of activity, use of sun protection must be followed in order to avoid potential complications, increased pain, and unsatisfactory result. Your physician may recommend that you utilize a long-term skin care program to enhance healing following a chemical skin peel. Successful post-operative function depends on both treatment and subsequent care. Physical activity that increases your pulse or heart rate may cause bruising, swelling, fluid accumulation and the need for return to treatment. It is wise to refrain from intimate physical activities after treatment until your physician states it is safe. It is important that you participate in follow-up care, return for aftercare, and promote your recovery after treatment.

FINANCIAL RESPONSIBILITIES

The cost of your procedure involves several charges for the services provided. The total includes fees charged by your physician, the cost of supplies, anesthesia, laboratory tests. The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from the treatment. Secondary treatment or hospital day-treatment charges involved with revision treatment will also be your responsibility. In signing the consent for this treatment/procedure, you acknowledge that you have been informed about its risks and consequences and accept responsibility for the clinical decisions that were made along with the financial costs of all future treatments.

Initial____ I understand and unconditionally and irrevocably accept this.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s), including no treatment. The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed-consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your doctor

may provide you with additional or different information which is based on all the facts in your particular case and the current state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent on this page.

CONSENT FOR TREATMENT

1. I hereby authorize Maria Romanenko, D.O. and NEW AGE MEDICAL CLINIC PA and such assistants as may be selected to perform the following procedure or treatment : CHEMICAL SKIN PEELS Infrared skin treatment, radiofrequency skin treatment, Botox and or Fillers.

I have received the attached information sheet :

2. I recognize that during the course of the procedure and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.

4. I understand what my doctor can and cannot do, and I understand there are no warranties or guarantees, implied or specific about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not. All of my questions have been answered, and I understand the inherent (specific) risks of the procedures I seek, as well as those additional risks and complications, benefits, and alternatives. Understanding all of this, I elect to proceed.

5. I consent to be photographed or televised before, during, and after the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.

7. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical device registration, if applicable.

8. I understand that the surgeon's fees are separate from the anesthesia and hospital charges, and the fees are agreeable to me. If a secondary procedure is necessary, further expenditure will be required.

9. I realize that not having the procedure is an option.

10. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND :
a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-10).

I AM SATISFIED WITH THE EXPLANATION.

_____

Patient or Person Authorized to Sign for Patient

Date _____ Witness _____

Sermorelin Acetate / Growth Hormone Releasing 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. 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. 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_____

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___

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___

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___

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___

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_____

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 be provided with or directed to a location which

provides 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_____

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.

Certain hormones, such as HGH, Sermorelin, Estrogen, Progesterone, Testosterone, and DHEA effect 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 of certain hormones, such as those named here, could induce further growth of the underlying cancer. Initial___

All questions I had regarding hormone replacement therapy has 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_____

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 age-related diseases as they appear. Initial___

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 waive 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.

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.

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. 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 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 diet 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

Clinical Features of Growth Hormone Deficiency

PLEASE CIRCLE YES OR NO

a. **YES OR NO** 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).

Patient Name

Patient Signature Date Witness/ Staff Member

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