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.
9) I consent to live encrypted audio & video monitoring during intake, physical exam and instructional sessions to Medical Director or other medical staff as necessary when off site. No video or audio sessions to be saved.

X _____ _____
Patient Signature Date

X _____ _____
Signature of Health Care Provider Date

PLEASE CIRCLE ALL CONDITIONS YOU CURRENTLY HAVE

COMMON ICD-9 CODES

Alphabetical Listing

789.07	Abdominal pain, generalized
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: ……

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

Botox ® Cosmetic/Dysport® Botulinum Toxin Type A Informed Consent

Instructions
This is an informed consent document that has been prepared to help inform you concerning Botox ® Cosmetic/Dysport® injections, its risks, and alternative treatment(s).

It is important that you read this information carefully and completely. Please discuss any questions you may have with your provider.

Introduction
Botox ® Cosmetic/Dysport® injections involve a series of small subcutaneous injections designed to weaken certain muscles that cause skin wrinkling. Weakening of the injected muscle begins to be apparent after 2-3 days with the peak effect being reached after 7-14 days. Results can last 3-6 months. The procedure can be repeated after 3 months; however, injections given at less than 3 month intervals may not produce a noticeable effect.

Please initial:
Alternative Treatments
_____Alternative forms of non-surgical and surgical management for the appearance of wrinkles and lines in the skin include laser ablation, chemical peels, dermal filler, and minimally invasive procedures and face lift. Alternative forms of treatment are all associated with certain risks.

Please initial:
Injector Discretion
_____Our highly trained injectors will select the brand or brands Botox ® Cosmetic/Dysport® of botulinum toxin Type A. They determine which brand will give you optimum results for each area treated. If you have a preference please let your injector know.

Risks of Botox ® Cosmetic/Dysport® Injections
Every procedure involves a certain amount of risks, and it is important that you understand the risks involved. An individual's choice to undergo a procedure is based on the comparison of the risk to potential benefits. Although the majority of patients do not experience these complications, you should discuss each of them with your provider to make sure you understand the risks, potential complications, and consequences of Botox ® Cosmetic/Dysport® injections.

- **Bleeding**: It is possible, though unusual, to experience localized bleeding episodes during or after the procedure at the sit(s) of injection. **Do not take any aspirin or anti-inflammatory medications for five days prior to your Botox ® Cosmetic/Dysport® injection appointment.**
- **Bruising:** Following this procedure, it is not uncommon to bruise at the injection site. Bruising usually resolves in 3-4 days.
- **Infection:** Infection is unusual. Should an infection occur, additional treatment including antibiotics may be necessary.
- **Unsatisfactory Results:** You may be disappointed with the results of the procedure. The procedure may results in unacceptable visible deformities, loss of function and/or loss of sensation.
- **Allergic Reactions:** In rare cases, local allergies to botulinum toxin type A preparations (including Botox ® Cosmetic/Dysport®) have been reported. Systemic reactions, which are more serious, may result from any medications or substance used during the procedure. Allergic reactions may require additional treatment.
- **Drooping of the eyelids (Ptosis):** This is rare but transient complication occurring in 1-2% of patients. The incidence can be minimized by positioning post injections. Ptosis usually resolves within several weeks but may take longer.
- **Additional Procedures:** Should complications occur, other treatments may be necessary. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with Botox ® Cosmetic/Dysport® injections. Although good results are expected, there cannot be any guarantee or warranty expressed or implied with regard to the results that may be obtained.

Client Signature: _____

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). 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. Informed consent documents are not intended to

define or source 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 this consent.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Client Name: _____

Signature: _____

Witness: _____ Date: _____