Holistic Medicine and Skin Care
1670 Route 34 N, suite 3C
Wall Township NJ 07727

Welcome to our office!

Your Name:	Last:	First:
DOB:	Month/Day/Year:	Age:
Address:	Address:	City:
	Apt/Ste:	State/Zip:
Contact:	Home phone:	Mobile:
	Work:	Fax:
	Email :	
How did you hear about us?		
What health issues are you looking to resolve or improve?		

I authorize and consent to the administration of all diagnostic and therapeutic treatments that may be considered by **Dr. Michael Rothman**, as medically indicated or necessary based upon prior discussion. I am aware that I have the final say so in all aspects of my medical management by Dr. Michael Rothman and/or his associates, representatives and appropriate office staff.

________________________________**and dated this**______________, ______ **20**____.
Signature

I acknowledge that I have received a copy of **MD Wellness, LLC**'s Notice of Privacy Policies, detailing how my information may be used and disclosure as permitted under federal law.

________________________________**and dated this**______________, ______ **20**____.
Signature

MD Wellness

HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (Last, First, M.I.)	☐M ☐F	DOB:
Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed		
HOME STATUS		
Do you live with others in your home?	☐Yes ☐No	
If Yes, How many people live in your home?	____________	
PERSONAL HEALTH HISTORY		
List Any Medical Problems That Other Doctors Have Diagnosed		
Surgeries:		
Year	Reason	Hospital
Other Hospitalizations:		
Year	Reason	Hospital
List Your Prescribed Drugs , Over-the-Counter Drugs, Vitamins or Nutritional Supplements and Inhalers: (*Please attach additional page, if necessary)*		
Name of Drug	Dosage	Frequency Taken
Allergies to Medications:		
Name of Drug	Reaction You Had	

FAMILY HISTORY

OTHER PROBLEMS

Sleep:	How many hours of sleep do you get each night?		
	Do you feel rested/ refreshed in the morning?	☐Yes	☐No
	Do you have trouble falling asleep?	☐Yes	☐No
	Do you have trouble staying asleep?	☐Yes	☐No
	Do you have trouble waking up too early?	☐Yes	☐No
Headaches:	Do you suffer from headaches?	☐Yes	☐No
	If Yes, please answer the following questions:		
	Does your headache affect both sides of your head or only one side?		
	Do you see "auras" (visible lights) prior to your headaches?	☐Yes	☐No
	Do you get nauseas with you headaches?	☐Yes	☐No
	Have ever been diagnosed as having "migraines"?	☐Yes	☐No
Fatigue:	Do you suffer from fatigue?	☐Yes	☐No
	If Yes, please answer the following questions:		
	Is your fatigue characterized by excessive sleepiness in the day?	☐Yes	☐No
	Do you feel "burnout"?	☐Yes	☐No
	Do you suffer from "brain fog"?	☐Yes	☐No
	Do you feel unmotivated?	☐Yes	☐No
Pain:	Do you suffer from pain?	☐Yes	☐No
	If Yes, please answer the following questions:		
	Do you have pain in your muscles?	☐Yes	☐No
	Do you have pain in your joints?	☐Yes	☐No
	Is your pain worse at any particular time of the day? Morning, afternoon or evening?	☐Yes	☐No
	Does activity make the pain worse or better?	☐Yes	☐No
	Is the pain alleviated with the application hot or cold compressions?	☐Yes	☐No
Low Blood Sugar:	Are you constantly hungry and need to eat several times each day?	☐Yes	☐No
	Do you, at times, feel hungry, anxious, weak, or unfocused and feel much better immediately after you eat?	☐Yes	☐No

REVIEW OF SYSTEMS

(please check appropriate boxes)

Constitutional:	☐Fever ☐Weight loss ☐Night sweats
Ears, Nose, Mouth and Throat:	☐Hearing Loss ☐Ear pain ☐Ear infections ☐Ringing in ears ☐Balance problems ☐Oral Thrust ☐Post Nasal Drip ☐Sinus Infections ☐Sinus headaches ☐Sore throat ☐Mouth Sores Did you have any recent dental work? ☐Yes ☐No If yes, when was the last visit? ___________________________ Did you have any silver filling or amalgam? ☐Yes ☐No If yes, when was the last removal? ________________________
Cardiovascular:	☐Chest pain ☐High blood press ☐Irregular pulse ☐Heart murmur ☐History of high LDL (bad cholesterol) ☐History of low HDL (good cholesterol) ☐ Elevated Triglycerides

Circulation:	Do you suffer from? ☐Cold Feet ☐Hands and Feet fall asleep ☐Cold Hands ☐Fingernail turn blue
Respiratory:	☐Asthma ☐Bronchitis ☐Chronic cough ☐Pneumonia ☐Emphysema ☐Sputum ☐Shortness of breath

Gastro-Intestinal:			
	Bowel Regularity:	Do you move your bowels every day? If not how many time each week?	☐Yes ☐No
		Do you take or eat things to help you to move your bowel (prunes, fibers…)?	☐Yes ☐No
		Do you suffer from loose stools or diarrhea more than once each month?	☐Yes ☐No
	Other gastro-intestinal Symptoms:	Do you suffer from heartburn or indigestion?	☐Yes ☐No
		Do you suffer from gas or bloating?	☐Yes ☐No
		Do you have problems with eating or your appetite?	☐Yes ☐No
		Do you feel "sick" after you eat?	☐Yes ☐No
		Do you have "food allergies"?	☐Yes ☐No
		If Yes, Please Specify:	
		Food	Reaction You Had

Genitourinary:	☐Urinary tract infect ☐Incontinence ☐Painful urination ☐Urgent Urination ☐Blood in urine ☐History of Kidney stones ☐Difficulty urinating Do you usually get up to urinate during the night? ☐Yes ☐No If Yes, How many times? ________________
Musculoskeletal:	☐Arm/leg weakness ☐Back pain ☐Neck pain Do you feel joint pain? ☐Yes ☐No In which joints? ____
Skin:	☐Dry skin ☐Oily skin ☐Eczema ☐ Itchiness ☐Fungal infection *(Athletes foot, jock itch)*
Endocrine:	☐Diabetes ☐Thyroid disease ☐Hormone Problems

MENTAL HEALTH

Neurological:	☐History of Seizures ☐ Inability to concentrate ☐Memory problems ☐ Vertigo Do you get dizzy if you stand up quickly? ☐Yes ☐No Do you find yourself in the middle of a task and then forget what you were doing? ☐Yes ☐No
Psychiatric:	Do you find yourself anxious at times? ☐Yes ☐No Do you feel depressed? ☐Yes ☐No

ENVIRONMENTAL

Do you have any rooms in your home or work that present the following?

History of leak or water damage?	☐Yes	☐No
Visible mold?	☐Yes	☐No
Musty or moldy smell?	☐Yes	☐No
Do you have a basement in your home?	☐Yes	☐No
If Yes, has it ever flooded?	☐Yes	☐No
Do you have pets? If Yes, what kind? ____	☐Yes	☐No

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

☐Sedentary (No exercise) ☐Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐Occasional Vigorous Exercise (i.e. work or recreation less than 4x week for 30 min)
☐Regular Vigorous Exercise (i.e. work or recreation 4x week for 30min or more)

Diet:

Are you dieting? ☐Yes ☐No
If yes, are you on a physician prescribed medical diet? ☐Yes ☐No

Number of meals you eat in an average day? ________

DO YOU CONSUME THE FOLLOWING FOODS?
(check appropriate box and circle appropriate items)
(Its important we understand because some foods you consume may be detrimental to your health)

☐Fried Foods (French Fries/ Fried Chicken/Mozzarella sticks/Onion rings/ Bacon)
How often do you eat Fried Foods? ___________________________________
☐Sweets (Cake/ Cupcakes/ Ice Cream/ Pies/ Candy bars)
How often do you eat Sweets? ______________________________________
☐Sugar ☐Artificial Sweeteners
How often in a day do you use these sweeteners?
____
☐Sweet Drinks (Sodas/ Fruit Juices/ Ice Coffees/ Energy Drinks/ Smoothies)
How often do you have sweet drinks?________________________________
☐Pre-packed food(Microwavable dinners / Lean Cuisine / HungryMan/ HealthyChoice)
How often do you eat Pre-packed foods? _____________________________
☐Oils - Vegetable/ Canola/ Corn/ Peanut/ Pam
How often do you consume oils? ___________________________________
☐Spreads - Smart Balance/Pam/ I Can't Believe It's Butter/ Margarine/ Butter
How often do you consume Spreads? ________________________________
How often do you consume Soy Products? ___________________________
What is your Typical:

Breakfast	Lunch	Dinner

Do You Snack During the day? ☐Yes ☐No
What do you snack on? ____
Do You Drink Water? ☐Yes ☐No
What Kind? ____
How Much Water Do you Intake Daily?
☐Less then 8oz ☐1-3 Glasses ☐4-6 Glasses ☐7-8 Glasses ☐More Then 8 glasses
Do You Eat Meat? ☐Yes ☐No
If Yes, How Do You Like It Prepared?
☐Rare ☐Medium Rare ☐Medium ☐Medium Well ☐Well Done

Caffeine: ☐None ☐Coffee ☐Tea ☐Cola Number of Cups/Cans per Day?

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All questions contained in this questionnaire will be kept strictly confidential.	
Alcohol:	Do you drink alcohol? ☐Yes ☐No If Yes, what kind? ____ How many drinks per week? ________________________________
Tobacco:	Do you use tobacco? ☐Yes ☐No ☐Cigarettes - Pks/day _____ ☐Chew -#/day _____ ☐Pipe - #/day _____ ☐Cigars - #/day _____ # of Years _______ or Year Quit _______
Sex:	Are you sexually active? ☐Yes ☐No If yes, are you trying for a pregnancy? ☐Yes ☐No If not trying for a pregnancy, list contraceptive or barrier method used ____ Any discomfort with intercourse? ☐Yes ☐No Are you satisfied with your sexual functioning? ☐Yes ☐No

WOMEN ONLY	
Do you still get your cycle?	☐Yes ☐No
Age at onset of menstruation	________
Date of last menstruation	________
Are your cycles regular?	☐Yes ☐No
What is the length of your cycle? (Normal cycle is 28 days)	________ Days
How many days do you bleed during your cycle?	________ Days
Do you bleed light, normal, or heavy?	________
Are your cycles painful?	☐Yes ☐No
Number of pregnancies?	________
Number of live births?	________
Are you pregnant or breastfeeding?	☐Yes ☐No
Any hot flashes or sweating at night?	☐Yes ☐No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	☐Yes ☐No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐Yes ☐No
Have you been diagnosed with Endometriosis?	☐Yes ☐No
Have you ever had vaginal yeast infections?	☐Yes ☐No
If Yes, how many times?	________
When was the last one?	________
Have you ever had Fibrocystic Breast Disease?	☐Yes ☐No
Have you ever had Polycystic ovaries?	☐Yes ☐No

MEN ONLY	
Do you feel burning discharge from penis?	☐Yes ☐No
Has the force of your urination decreased?	☐Yes ☐No
Do you have any problems emptying your bladder completely?	☐Yes ☐No
Any difficulty with erection or ejaculation?	☐Yes ☐No
Any testicle pain or swelling?	☐Yes ☐No

Dr. Rothman's Weight Loss Program

TERMS OF SERVICE

FDA DISCLAIMER
This weight reduction treatment includes the use of hCG, a drug which has not been approved by the food and drug administration as safe and effective in the treatment of obesity or weight control. There is no substantial evidence that hCG 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-restrictive diets. The FDA has not approved hCG for weight loss.
The FDA, National Institute of Health and the manufactures of the hCG advise the "hCG had no knows effect for fat mobilization, reducing appetite or sense of hunger, of body fat distribution."

GUARANTEE OF RESULTS
I understand that results may vary once I have begun the protocol I am committed to follow through.
I understand that the program and medication may involve risk. I understand that there are no refunds, returns or store credit for the medication, nutritional supplements or medical consultations. There is no weight loss guarantee with this program. I have read and understand the information given to me about this medication. I have asked and had answered any questions that I may have after reading this form. I understand that I may quit the program at any time. I agree to stop hCG if I become pregnant and agree to advise its physicians should I decide to become pregnant. No adverse side effects or complications are expected, but in the event that an illness does occur, I understand that I need to contact the office. Its physician is serving as your consultant, not your primary care physician, during the course of this program. If I experience an emergency situation, I understand that I need to go to an emergency facility. I realize that its physician cannot offer any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue treatment at any time.
I have read and understand all of the above and have been informed of potential side effects and risks that may be associated with hCG protocol. I fully understand what I am signing and hereby request and consent to weight loss treatment using hCG.
YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION ABOVE, HAVE HAD YOUR QUESTIONS ANSWERED, HAVE HAD HAD POTENTIAL SIDE EFFECTS EXPLAINED, AND AGREE TO NOTIFY ITS PHYSICIAN OFFICE OF ANY CHANGE IN YOUR HEALTH STATUS OF MEDICATION PRESCRIBED. I CERTIFY THAT I HAVE READ AND UNDERSTAND THE DIET NECESSARY TO ACHIEVE SUCCESS ON THIS PROGRAM. I WILL FOLLOW THE DIET STRICTLY.

Patient's Name: ____

Signature: ____

Date: ____________________

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Patient Treatment Agreement

By signing this form:

- ☐ I confirm that specific verbal and/or written instructions regarding my diet and the use of nutritional supplements have been provided to me by Dr. Rothman and/or the staff at MD Wellness, and that I agree to comply with these instructions.
- ☐ I agree to follow any future instructions and accept responsibility to request clarification on any such instructions that may be unclear, or it will be assumed as understood and agreed.
- ☐ I am aware that it is necessary to follow the preparation steps for the metabolic typing test prior every visit, otherwise the test results may be compromised.
- ☐ I acknowledge that it is crucial to adhere to scheduled follow-up appointments, and that failure to do so may result in treatment complications and/or adverse effects.
- ☐ I recognize that if it is absolutely impossible to keep my scheduled appointment, I am strongly encouraged to give as much advance notice as possible to ensure a new appointment is secured within an acceptable time frame.
- ☐ I understand that MD Wellness is a "no wait" practice, therefore it is highly recommended to arrive at least 15 minutes prior to my scheduled appointment time. Further, I am aware that arriving late for my appointment will decrease my consultation time with Dr. Rothman, however I will be charged in full for the original time allocated to my appointment.

___________________________________ ______________________

Print full name **Date**

____

Signature

Note to patient: Please maintain a copy of this release form in your files.

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Medical Services Agreement

______________________________(PATIENT) and MD Wellness (Dr. Michael E Rothman.) hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT agrees not to submit a health insurance claim (or request the PHYSICIAN to submit a claim on PATIENT'S behalf) under the Social Security Act (MEDICARE) for the services, even if you may think that such services are or maybe otherwise covered under health insurance or MEDICARE.

2. **The PATIENT agrees to be responsible for the SERVICES.** Although metabolic balancing therapy is medically beneficial, insurance companies have not yet accepted this position. At this point in time, neither insurance companies nor MEDICARE will reimburse for preventive care or metabolic balancing therapy. As a result of this, medical records will not be provided to any insurance company or MEDICARE. The United States Department of Health and Human Services, Office of Inspector General takes the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this, it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government.

3. The PATIENT acknowledges that health insurance companies or "Medigap plans" (42 U.S.C., section 1882) will not provided reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a",'- 1848g) **will** apply to the amounts PHYSICIANS charge for their SERVICES.

4. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.

5. Our **INVOICE** contains pertinent information regarding your office services and purchases. This form was generated for your personal records only although; patients have submitted it to their insurance company with a claim form for reimbursement. **This frequently causes subsequent inquiries by the insurance company to which we do not respond**.

Patient's Signature ______________________________ Date: ______________

Physician Signature ______________________________ Date: ______________

Witness Signature ______________________________ Date: ______________

MD Wellness

Notice of new HIPAA Guidelines for MD Wellness Patients

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your medical reports, appointment confirmations and/or receivables of lab results:

I wish to be contacted in the following manner(s):

☐ **Home Phone**
Leave message with detailed information
Leave message with call back number

(   )______________________________
Home number

☐ **Mobile Phone**
Leave message with detailed information
Leave message with call back number

(   )______________________________
Mobile number

☐ **E-mail Report**

____
e-mail address

☐ **Written Communications**
Please continue to send to my home

____
____
____
Mailing Address

____
Print full name **DOB**

____
Patient's signature **Today's date**

Note to patient: Please maintain a copy of this release form in your files.

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Insurance Disclaimer

Dear Patient,

Metabolic Balancing is a unique and rapidly growing form of alternative medicine, which is not recognized by the insurance industry. It is viewed as a form of General Health and/or Aesthetic Medicine making it a non-reimbursable service.

More so, due to both state and federal issues relating to billing for office visits, we have been advised by legal counsel to disassociate from all forms of third party insurance programs. We therefore, are not contracted or participate with any insurance companies and no longer supply the following:

____ 1. Insurance billing forms.
____ 2. Standardized Service codes.
____ 3. Standardized Diagnostic codes.
____ 4. Transmit any information to any insurance company or their representatives.

Print full name   Today's date.

Patient's signature

Note to patient: Please maintain a copy of this release form in your files.

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MD Wellness *Physician-patient e-mail communication consent form*

Risks of using e-mail

The physician offers patients the opportunity to communicate by e-mail. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via e-mail without understanding and accepting these risks. The risks include, but are not limited to, the following:

• The privacy and security of e-mail communication cannot be guaranteed.
• Employers and online services may have a legal right to inspect and keep emails that pass through their system.
• E-mail is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the e-mail once it has been sent.
• E-mails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
• E-mail can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. E-mail senders can easily misaddress an e-mail, resulting in it being sent to many unintended and unknown recipients.
• E-mail is indelible. Even after the sender and recipient have deleted their copies of the e-mail, back-up copies may exist on a computer or in cyberspace.
• Use of e-mail to discuss sensitive information can increase the risk of such information being disclosed to third parties.
• E-mail can be used as evidence in court.
• The physician uses encryption software as a security mechanism for e-mail communications.

Conditions of using e-mail

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of e-mail communication.
• The patient is responsible for informing the physician of any types of information the patient does not want to be sent by e-mail. Such information that the patient does not want communicated over e-mail includes:
____

____

The patient can add to or modify this list at any time by notifying the physician in writing.

The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the physician and me, and consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with patients by e-mail. I acknowledge the physician's right to, upon the provision of written notice; withdraw the option of communicating through e-mail. Any questions I may have had were answered.

Patient's signature:____
Date:_________/_________/___________

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MD WELLNESS APPOINTMENT CANCELLATION, CHANGE AND "NO-SHOW" POLICY

At MD Wellness, we strive to provide excellent patient care and customer service. To that end, appointments are all scheduled in advance, and are lengthy enough (thirty minutes to two and half hours) to provide sufficient time to get to the root cause of your problems. Also we do NOT overbook our schedule (unlike most other doctor's offices) at MD Wellness and therefore waiting times are usually nonexistent or very short (rarely more than 15 minutes)
Dr. Rothman's services are in very high demand, and his schedule is filling up weeks in advance. Many people are seeking his care to help them solve their chronic health related issues. Unfortunately, we are experiencing a large amount of "no-shows", "last minute" cancellations and changes to our schedule. Apparently a substantial percentage of patients are making appointments only to change their plans at the last moment.
The Doctor's time is scarce and valuable and when you make an appointment with him, this time is reserved just for you. These last minute changes are very problematic, creating large "holes" in our schedule while simultaneously depriving other patients the chance to see Dr. Rothman.
We are therefore announcing a new policy at MD Wellness to help mitigate against these scheduling problems;

New patients will pay a 25% deposit for their visit at the time they make their initial appointment. Any changes for a new patient must be made at least three MD Wellness regular business days prior to your scheduled appointment. MD Wellness regular business hours are Monday / Wednesday 9:00 AM – 2:00 PM, Friday 9:00 AM – 5:00 PM, Thursday 9:00 AM – 6:00 PM and Tuesday from 9:00 AM – 7:00 PM. Cancellations or changes made less than 3 regular business days prior to your appointment will result in a forfeiting of your security deposit. Follow up patients will be also be subject to a 25% cancellation fee unless notice is given 3 regular MD Wellness business days prior to your appointment.

Patients that are chronic offenders of our cancellation policy will be required to pay the full cost of their visits in advance.

At MD Wellness, we understand that true emergencies arise that require last minute changes to your schedule. In case of a true emergency, we request that you provide some sort of evidence to substantiate your emergency. True emergencies will not be subject to the aforementioned fees.

Our services are very scarce and valuable. We strive to treat every person with great care, compassion and respect. We expect our patients to reciprocate by treating us the same way.

I_______________________________________ fully understand and agree with the MD Wellness cancellation and rescheduling policy

Print Name ____ Date ____/____/____

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Credit/Debit Card Authorization Form

I ____ hereby authorize **MD Wellness and MD Skin** to charge $ to my Credit Card(s) listed below for consultations, "late cancellation" and "no show" fees. This authorization will remain on file until I cancel this authorization in writing.

Name: ____
(Please Print)

Address: ____
(Please Print) Street City State Zip

Home phone: ____________________________ Cell: ____________________________

Credit card Information

Name: ____
(Please Print – As shown in the Card)

Billing Address: ____
(Please Print) Street City State Zip

Credit Card Type: Visa Master Amex Discover Other: ________

Credit Card Number: ____

Expiration Date: _____/_____ Security Code (CID): ___ ___ ___

MD Wellness Return and Exchange Policy

Products and supplements must be in an unopened package.
Returns must be done within 30 days of the purchase date.
Liquid supplements are non-refundable.
Shipping and Handling fees are non-refundable.
HCG pellets are nonrefundable
There is a 10% restocking fee taken from the price of the return. Air purifying products require 15% restocking fee.
All returns are subject to exemptions and evaluation by management

_______________________________________ _________________________
Signature Date

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