

**THE CLEANSING CLINIC
INTAKE EVALUATION**

Name: _____ **Date:** _____/_____/_____

Address: _____ **Phone:** (____) _____

_____ **Email:** _____

Date of Birth: _____/_____/_____ **Gender:** M F **Marital Status:** S M D W

Age: _____ **Height:** ____' ____" **Weight:** _____ lbs.

Emergency Contact: Name: _____ **Phone:** _____

WHAT SERVICE(S) ARE YOU HERE FOR? _____

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. When and where did you last receive health care?

For what reason?

2. Has your case been referred to an attorney? Y N (circle one)

3. Please identify the health concerns that have brought you to The Cleansing Center in order of importance:

Condition

Past Treatment

a. _____
How does this condition affect you? _____

b. _____
How does this condition affect you? _____

c. _____
How does this condition affect you? _____

d. _____
How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive of allergic to (please include reaction)

Please list any medications (prescribed and over the counter), vitamins and supplements you are currently taking

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

5. Do you have any reason to believe you may be pregnant? Y N (circle one)

If "Yes" How far along are you or may you be? _____

6. Do you have any infectious diseases? Y N (circle one)

If "Yes" Please Identify: _____

7. **Family History** (check those that apply)

	Father	Mother	Brothers	Sisters	Spouse	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						

8.

(10 year) Past Max Weight: _____ Past Min Weight: _____

9. **Blood Pressure:** What is your most recent blood pressure reading? ____/____ Taken: __/__/_____

10. **Childhood Illness:** (circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Immunizations:** (circle any that you have had):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria HiB Hepatitis-B

12. **Hospitalizations and Surgeries:**

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

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

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

For the following questions:

(circle any that you experience now and underline any you have experienced in the past)

14. **Emotional :**

Mood Swings Nervousness Mental Tension Irritability Depression Grief Obsessive Thinking

15. **Energy and Immunity :**

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **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

17. **Respiratory :**

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy

Asthma Tuberculosis Shortness of Breath Other Respiratory_____

18. Cardiovascular :

Hearth Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering Stroke
Heart Murmurs Rheumatic Fever Varicose Veins

19. Gastrointestinal :

Ulcers Changes In Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn Belching
Gallbladder Disease Liver Disease Hepatitis A or B Hemorrhoids Abdominal Pain

20. Genito-Urinary Tract :

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow
Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

21. 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

22. Male Reproductive :

Erectile Dysfunction Prostrate Problems Testicular Pain/Swelling Penile Discharge

23. Musculoskeletal :

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain Lower Back Pain
Leg Pain Joint Pain

24. Neurologic :

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

25. Endocrine :

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

26. Menstrual/Birthing History

Age of first Menses: _____
Of Days of Menses: _____
Length of Cycle: _____
Birth Control Type: _____

of Pregnancies: _____
of Miscarriages: _____
of Abortions: _____
of Live Births: _____

27. Other :

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

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/Alcohol/Caffeine Use:

h. Have you experienced any major traumas? Y N Explain: _____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Interests and Hobbies:

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Hypertension _____ Hepatitis _____ Renal _____ Respiratory _____ Diabetes _____ Stroke _____
Heart Disease _____ Seizures _____ Mental Health Issues _____ Renal Disease _____ Abnormal
Bleeding _____ Glaucoma _____

ARE YOU EXPERIENCING CONSTIPATION: yes / no

Does it feel like there is more feces stuck in you after having bowel movement?: yes / no

Do you have a diet with low fiber and high meat/cheese or processed foods: yes / no

Incontinence: yes / no | Pain: 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

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) Kenneth Lewandowski, D.O. and The Cleansing Clinic, Inc. 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 Cleansing Center/Clinic serves as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness; and 4) that all supplied information is accurate and forthcoming.

X _____
Patient 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:

The Cleansing Center / Clinic 90 Millburn Ave., Suite 201, Millburn NJ 07041

FAX: 973-313-0062 PHONE: 973-313-0028

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:

The Cleansing Center / Clinic 90 Millburn Ave., Suite 201, Millburn NJ 07041 PHONE: 973-313-0028

Or FAX to 973-313-0062

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

HIPPA

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I, _____, (patient’s name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility’s Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility’s Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I’ve provided if requested.

Signature of PatientDate:

HIPAA Privacy Rule of Patient Authorization & Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility’s notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility’s Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I’ve provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility’s procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient Date:

Informed Consent COLONICS

Patient Name _____ Age _____ Date _____

The Cleansing Clinic 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 The Cleansing Clinic given their familiarity with patient’s underlying medical history and response to medications received.

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

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

Treatments may have risk factors listed or cause the side effects listed below. However, as these treatments 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

CONTRINDICATIONS FOR COLON HYDROTHERAPY / COLONICS: DO YOU HAVE:

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 |

I acknowledge I do not have ANY of the above referenced contraindications for Colon Hydrotherapy.

X _____
Patient Signature Date Healthcare Provider Date

Informed Consent IV Chelation & IV Nutrients (1 of 3 pages)

Patient Name _____ Age _____ Date _____

The Cleansing Clinic does NOT treat or cure any diseases and any services performed by staff / treatments received by patients, are designed to improve overall nutritional wellbeing of our patients. X _____ (patient initials)

Patient agrees to consult with primary care physicians as to the safety and efficacy of the treatments provided by staff at The Cleansing Clinic given their familiarity with patient’s underlying medical history and response to medications received. X _____ (patient initials)

Patient understands that the treatments provided by staff at The Cleansing Clinic are experimental in nature as there is not significant peer reviewed medical literature supporting the use of such therapies. X _____ (patient initials)

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

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

I understand that Chelation Therapy is a standard therapy widely approved for the treatment of heavy metal toxicity and that EDTA is an FDA-approved drug; however, the use of EDTA for treating atherosclerotic vascular disease and other degenerative diseases is what is called “off label” use of the drug. The usage of EDTA is considered controversial for the generalized treatment of atherosclerotic vascular disease and other degenerative diseases, and a minority of the medical community accepts the view that it is of benefit in the treatment of such disorders. Opponents consider such use of EDTA to be “experimental.”

WOMEN of Child Bearing Years:

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

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

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

Side effects / Potential risks:

Kidney Toxicity:

In the early 1950s several deaths occurred from kidney toxicity after EDTA treatment. At that time the dosage used was around 10 grams per infusion. The recommended dose now is 3 grams. Kidney toxicity is related to size (quantity) of the dose and the rate of infusion. Experienced therapists adjust dosage so that the infusion will not harm the kidney. Indeed, research has shown that, properly administered, chelation therapy improves kidney function, especially if there is any impairment present to this vital organ. However, if the patient is very elderly, or has low parathyroid activity or is suffering from heavy metal toxicity which is damaging the kidney, treatment should be modified to use less EDTA less frequently (once per week perhaps). Heavy metals damage the kidneys and too rapid infusion can overload them. Heavy metals most likely to produce kidney damage during infusion therapy are lead, aluminum, cadmium, mercury, nickel, copper and arsenic.

Renal function tests should always be performed before chelation therapy is started. In any case of significant renal impairment, lower dosage of EDTA infusions should be used. Use extreme caution. Also make sure that the patient has sufficient periods of rest between the infusions. X _____ (patient initials)

Informed Consent IV Chelation & IV Nutrients (2 of 3 pages)

Excessive Removal of Calcium with Disodium EDTA:

If, through inexperience or error, there is too rapid an infusion (or too much EDTA used), levels of calcium in the blood can drop rapidly, resulting in cramps, convulsions or possible cardiac arrest. An injection of calcium gluconate generally swiftly rectifies such abnormal reactions. This is with Disodium EDTA (3 hour dosage). This is NOT a concern with Calcium Disodium EDTA. X_____ (patient initials)

Inflammation of a vein:

If an infusion into a vein is performed too rapidly, inflammation may occur. Staff may need to reduce the dosage and dilute EDTA or IV Nutrients infusion mix and administer the infusion very slowly. X_____ (patient initials)

Insulin shock and hypoglycemia:

During EDTA infusion it is possible that blood glucose may drop, leading to insulin shock. This is more likely to happen to diabetic patients. Patients having EDTA infusions are advised to have a snack before or during the three hours plus treatment period. Avoid dairy products that are high in calcium. Eat complex carbohydrates; avoid foods containing sugar such as ripe bananas. You may eat a fruit during infusion, if needed.

If you are diabetic and is taking zinc-bound insulin, there is a risk of too rapid a release of insulin, leading to hypoglycemia and shock. If you are diabetic; test your sugar before, during and after your session; if it drops radically let us know; we are equipped to administer D50 to stabilize your glucose levels. It has been found that, most people need less insulin while undergoing chelation therapy. X_____ (patient initials)

Aluminum, Mercury, Cadmium and other metals:

EDTA has been approved by FDA for removal of Lead. The Cleansing Clinic utilizes EDTA off label in an attempt to chelate other metals as well. There are other chelating formulas that have been approved for use in chelating other metals but our staff believes that they are not as safe nor as effective as utilizing EDTA. I understand the implications of utilizing medications off label and that EDTA has no controlled studies to determine the safety and efficacy of removing metals other than lead.

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

If the heart is already unable to cope adequately with the movement of fluids, and there is evidence of congestive heart failure (extreme shortness of breath, swollen ankles) and/or if digitalis-like medication is being taken, extreme care is needed over chelation infusions, since EDTA prevents digitalis from working adequately. Avoid sodium EDTA for such people as it could increase the fluid retention tendency. Use a 5 per cent dextrose and water instead. X_____ (patient initials)

Patient acknowledges that there are **no definitive tests to determine the exact levels of toxic metals in your system.**

Blood, hair, fecal, radiographic, or challenge urine toxicity testing is only a general determinant that toxic metals are in your system; as metals settle into different organs depending on age, metal and nutritional status. We utilize challenge urine toxicity testing as a general indicator of toxic metals.

Many laboratory tests are formulated to show heavy metal levels without use of a chelating agent (EDTA or DMSA) use of such chelating agent will greatly increase the metal levels shown and will exaggerate the results by pulling the metals from soft tissue and bone; and therefore can not accurately predict levels of heavy metals; but will show a rough estimate of what metals are coming out of your system. There are safe levels of toxic metals according to government standards; but in Preventive Medicine the ideal is to eliminate completely ALL toxic metals.

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

The nature and purpose of a proposed treatment or procedure: Disodium EDTA | Calcium Disodium EDTA | IV vitamin C | IV supplements

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

Informed Consent IV Chelation & IV Nutrients (3 of 3 pages)

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

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

X _____
 (Patient Signature) Date

X _____
 Cleansing Clinic Staff Date

Informed Consent HCG Diet (page 1 of 2)

Patient Name _____ Age _____ Date _____

The Cleansing Center/Clinic does NOT treat diseases and any services performed by staff, are designed to improve overall nutritional wellbeing of our patients.

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.”** X _____

“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.” X _____

Patient agrees to consult with primary care physicians as to the safety and efficacy of the treatments provided by staff at The Cleansing Center 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 The Cleansing Center 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 X _____ (women in child bearing years must receive pregnancy test if they have had sexual intercourse since last menstrual period unless they have had a hysterectomy.) **\$20 extra**
- I agree that I will take precautionary measures with birth control during this time frame. X _____

- The patient's diagnosis, if known: **obesity | constipation | bloating | heart burn / acid reflux | gas | abdominal pain | sleep apnea | back pain | (other)** _____
- The nature and purpose of a proposed treatment or procedure: **Hcg Diet**
- The benefits of a proposed treatment or procedure: **Weight Loss**

MEDICARE PRIVATE CONTRACT (page 1 of 2)

ALL CLIENTS 64 & Older MUST SIGN THIS!!

This agreement is entered into by and between The Cleansing Clinic, Inc./ Kenneth Lewandowski, 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

