Active WELLNESS INSTITUTE

ACTIVE WELLNESS LIFESTYLE PROGRAM

CONGRATULATIONS on taking your first step towards reaching your weight loss and aesthetic goals! You will be qualified based on several factors including medical history and your level of commitment to achieving your desired results. During your consultation we will evaluate your areas of concern and see if you qualify for one of our treatment programs. Your success relies on your dedication and compliance during your short time with us.

<u>Purpose for baseline test – Consultation Session:</u>

1. Perform baseline tests to determine your body's response and absorption to laser light energy.
2. Demonstrate the effectiveness of our technology.
3. Treatment protocols are individualized and specific, your program will be determined after baseline test to assure maximal results.

<u>Consultation Session Qualifications:</u>

- Serious candidates only
- Must be at least 18 years of age or older

<u>If selected:</u> (please choose one of the following)

☐ I would like to start a program today
☐I am committed to achieving my goals and would like to discuss program options that meet my needs and budget ☐
I am not interested in starting a program

I consent to receiving a health screening. I realize that I am not receiving a diagnosis treatment or prognosis for any medical or other condition that I may be experiencing I acknowledge that I am receiving a demonstration only and agree to hold harmless the facility, owners, employees, and any subsidiaries from any damage resulting from this demonstration. I understand and accept that visual documentation is necessary for evaluation program monitoring and marketing I hereby release and hold harmless this clinic and InvisaRED technology from any reasonable expectation of privacy, or a confidentiality associated with the images specified above. I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type.

PATIENT NAME: ____

PATIENT SIGNATURE: ______________________________ DATE: ______________

ACTIVE WELLNESS LIFESTYLE PROGRAM

Patient Intake Form

FIRST NAME:______________________________ LAST NAME:____

BIRTH DATE:_________/__________/_________ AGE: ___________ GENDER:______________________________

ADDRESS: ____

CITY:____STATE:___________________ ZIP CODE:_________________

WORK PHONE: _________________________________ HOME PHONE:___________________________________

CELL PHONE:___________________________________OCCUPATION:___________________________________

PATIENT EMAIL ADDRESS: ____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ___________________

HOW DID YOU FIND OUT ABOUT THE ACTIVE WELLNESS LIFESTYLE PROGRAM?

1. ☐ REFERRED BY A CURRENT PATIENT, NAME: ____
2. ☐ RADIO ☐ TV ☐ NEWSPAPER ☐ FACEBOOK/IG ☐GOOGLE ☐OTHER: ___________________

Please answer the following questions

Current Weight: _______ Ideal Weight: ________

How many inches would you like to lose? ________ How quickly would you like to reach your goal?___________

Areas of Concern (choose two): ☐ Waist ☐ Hip ☐ Thighs ☐ Butt ☐ Back ☐ Arms

What was your weight: One year ago: _____ 5 years ago: _____

When did you last feel your best?: ____

What have you tried in the past to lose weight?: ____

How did that work for you?: ____

How has your weight affected you emotionally: ____

How has your weight affected you physically: ____

Are any of the following items a potential obstacle to reaching your goals? ☐ Time ☐ Budget ☐ Commitment ☐Spouse/Partner ☐ Family ☐ Accountability ☐ Other (Please Explain)

What is your motivation?: ____

What is one thing you want to do again when you reach your goals?: _____________________________________

How will that make you feel?: ____

On a scale of 1-10, how serious are you about accomplishing your goals?											
Less Serious	1	2	3	4	5	6	7	8	9	10	Most Serious

How soon are you ready to get started? ☐ Today ☐ Next Week ☐ Next Month ☐ Next Year

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Primary Physicians Name:		Physician's Number:	
Current Medical Conditions, Disorders, and Diseases:			
☐ Cancer	☐ Cardiovascular	☐ Vascular Disease	☐ Autoimmune Disease
☐ Epilepsy	☐ Diabetic	☐ Skin Disorder	☐ Tattoo with Metallic Ink
☐ Endocrine Disease	☐ Pregnant/Nursing	☐ Surgically implanted electrostimulation device	

Please Check all Symptoms that have applied to you in the last 6 months		
☐ Fatigue	☐ Back Pain / Sciatica	☐ Digestive Problems
☐ Stress	☐ Neck / Arm Pain	☐ Constipation
☐ Irritable	☐ Headaches	☐ Diarrhea
☐ Low Energy	☐ Shoulder Pain	☐ Reflux / Bloating
☐ Cannot lose weight	☐ Knee Pain	☐ Thyroid Disease
☐ Cannot lose inches	☐ Hip Pain	☐ Gall Bladder / Pancreatis
☐ Brain Fog	☐ Plantar Fasciitis	☐ Diabetes
☐ Depression	☐ Muscle Aches	☐ Dehydration
☐ Anxiety		☐ High Blood Pressure
☐ Poor Sleep		☐ Heart Disease
☐ ADHD		☐ Cancer
☐ Shortness of Breath		☐ High Blood Sugar
		☐ High Cholesterol
Explain Any Checked Boxes:		

PERSONAL GOALS			
☐ Change your body	☐ Increase strength	☐ Lower Blood Pressure	☐ Reduce Stress
☐ More Confidence	☐ More Energy	☐ Sleep Better	☐ Feel Better
☐ Other:			

SELECT PROGRAM(S) OF INTEREST:	
☐ Weight Loss	How much?:
☐ Fat Loss	Area of Concern:
☐ Lose Inches	Area of Concern:
☐ Body Contouring	Area of Concern:
☐ Cellulite	Area of Concern:
☐ Nutrition	Area of Concern:

Do you smoke?	☐ No	☐ Yes	# Packs per week
Do you drink alcohol?	☐ No	☐ Yes	# Drinks per week
Fast Food / Dine Out?	☐ No	☐ Yes	# of Times per week
Do you exercise?	☐ No	☐ Yes	How often?
Do you take supplements?	☐ No	☐ Yes	If yes, please list

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What do you typically have for:	
Breakfast:	
Lunch:	
Dinner:	
Snacks:	
Desserts:	
Drinks:	

CHOOSE TWO OF YOUR FAVORITE AEROBIC ACTIVITIES:

☐Walking ☐Jogging ☐Cycling ☐Step Aerobics

☐Jumping Rope ☐Swimming ☐Stair Master ☐Stationary Bike

MEDICATIONS:

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ No ☐ Yes: ______________________________

PLEASE INDICATE IF YOU ARE **ALLERGIC** TO ANY OF THE FOLLOWING MEDICATIONS

☐ Synthroid
☐ Tenuate
☐ Diethylpropion
☐ Fastin
☐ Thyroid Extract
☐ Librax
☐ Phentermine
☐ Phendimetrazine
☐ Herbal Medications
☐ Cytomel
☐ Adipex-P

	LIST ALL MEDICATIONS AND DOSEAGES YOU ARE CURRENTLY TAKING:	
	Name	Dosages
1		
2		
3		
4		
5		
6		

Are you currently or have you previously taken any of the following prescribed weight loss medications? Check the box for "yes" and leave blank for "no"

☐Ozempic (Semiglutide) If yes, when and for how long?

☐Rybelsus (Semaglutide) If yes, when and for how long?

☐Wegovy (Semaglutide If yes, when and for how long?

☐Trulicity (Duraglutide) If yes, when and for how long?

☐Victoza (Liraglutide) If yes, when and for how long?

☐Saxenda (Liraglutide) If yes, when and for how long?

☐Byetta (Exenatide)	If yes, when and for how long?
☐Bydureon BCise (Exenatide)	If yes, when and for how long?
☐Mounjaro (Tirzepatide)	If yes, when and for how long?
☐Other:	If yes, when and for how long?

DO YOU HAVE ANY SERIOUS MEDICAL PROBLEMS? ☐ No ☐ Yes: ______________________________

____

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING? If yes, please explain:

Obesity	☐No	☐Yes:
Diabetes	☐No	☐Yes:
Cardiovascular	☐No	☐Yes:
Hypothroidism	☐No	☐Yes:
Hyperlipdema	☐No	☐Yes:
Pancreatitis	☐No	☐Yes:
Thyroid Cancer	☐No	☐Yes:
Gallbladder Disease	☐No	☐Yes:
Multiple Endocrine Neoplasia Type 2	☐No	☐Yes:

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Thinning of Eyebrows	☐No	☐Yes	Fatigue	☐No	☐Yes
Low Sex Drive	☐No	☐Yes	Abdominal Bloating	☐No	☐Yes
Dry or Thinning of Hair	☐No	☐Yes	Thickening of the Skin	☐No	☐Yes
Puffy Face	☐No	☐Yes	Cold Intolerance	☐No	☐Yes
Depression	☐No	☐Yes	Cold Hands or Feet	☐No	☐Yes
Joint or Muscle Pain	☐No	☐Yes	Thin, brittle fingernails	☐No	☐Yes

I hereby authorize that all information provided above is correct and is filled out to the best of my knowledge.

PATIENT SIGNATURE: ______________________________ DATE: ________________

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FOR CLINIC USE ONLY

Patient Name: ________________________________ **DOB:** ____________________

Patient Goals

SEMAGLUTIDE		LIPOLASER	
<10 lbs	4 weeks	Contour / Tone	12 sessions
<15 lbs	8 weeks	1-2”	18 sessions
<30 lbs	12 weeks	3”+	24 sessions

These are General Recommendation Guidelines based on Patient Goals. Results vary by patient and are not guaranteed.

Base on Patient Goals & Evaluation:				
Accepted for Care: ☐ Yes ☐ No				
Recommendation	**Semaglutide**	4 weeks	8 weeks	12 weeks
	LipoLaser	12 sessions	18 sessions	24 sessions
Patient Selected	**Semaglutide**	4 weeks	8 weeks	12 weeks
	LipoLaser	12 sessions	18 sessions	24 sessions

Complications:	
Contraindications:	

TEST REULTS

Weight: ________ **Height:** ________ **Age:** ________

Skeletal Muscle Mass:______ **lbs** **Below** **Average** **Above**

Body Fat Mass: ________ **lbs** **Below** **Average** **Above**

Percent Body Fat: _______ **%** **Below** **Average** **Above**

BMI: ______**kg/m2** **Underweight** **Normal** **Overweight** **Obese** **Extreme**

CHARTS

BMI

% Body Fat

MEASUREMENTS

Upper Waist: Pre: ____ Post: _____

Mid Waist: Pre: ____ Post: _____

Hips: Pre: ____

R Thigh: Pre: ____

L Thigh: Pre: ____

Chest: Pre: ____

R Arm: Pre: ____

L Arm: Pre: ____

Skin Tone: Light Medium Dark

Energy Setting: Light: ____ Medium:_____ Dark:_____

Time: 15 min Pulse Setting: 3.5 Delay: 0.2

Photos Take: Yes No Area: _____________

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Active Spine and Joint Institute (ASJ)
General Informed Consent

Name ____ Date __________________________

I have sought the clinical and health care services of Active Spine and Joint Institute for my personal healthcare or for my child or children who are minors. I understand that this health practice uses some approaches and methods that are known as complementary, alternative, holistic, experimental, investigational, or functional in nature. This may not be covered by my insurance plan or might not be generally accepted by mainstream medicine. This may include, but are not limited to, dietary and nutritional supplement advice, injections, regenerative medicine, human cell tissue products, platelet rich plasma, certain dietary/exercise protocols to follow, and certain metabolic tests that are used for informational purposes. Furthermore, the information gained from laboratory and evaluation tests may be interpreted differently from mainstream medical doctors. Approaches for improving general health and nutrition may be based upon the tests/evaluations and philosophies of complementary/functional/holistic/alternative medicine and may or may not be consistent with mainstream medical tests/evaluations and philosophies.

Although prescriptions and over-the-counter medications are used when your physician deems it necessary, foods, vitamins, minerals, enzymes, herbs, and other nutritional approaches may also be chosen as therapy or as adjunctive to medical therapies. It is your responsibility to ensure you inform your medical doctor of all supplements/diets you will be partaking in so that he/she can make sure there are no contraindications to your medicine. We will be glad to discuss and confer with your medical doctor concerning these supplements/diets if he or she wishes to do so and with your approval.

In addition to recommending oral or IV nutritional supplements it is not uncommon that our office might use products/approaches that are not FDA (Food and Drug Administration) approved or evaluated for any condition though are in compliance and permitted to be used pursuant to the federal Dietary Supplement Health and Education Act of 1994.

Our programs are exclusively an office-based operation. We are not affiliated with a local hospital. As a result, WE STRONGLY RECOMMEND THAT IN ADDITION TO OUR SERVICE, YOU MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFIED TO CARE FOR YOUR INDIVIDUAL HEALTH CONDITIONS. For example, in case of children we advise you seek the advice of a pediatrician; if you have cardiovascular disease consult a cardiologist; and if you have cancer consult with an oncologist; if you have any other degenerative conditions like, Diabetes, Lupus, Lou Gehrig's disease (ALS), Multiple Sclerosis, or any other auto-immune disease seek the advice from the appropriate medical professional. We often refer patients to these and other healthcare professionals when it is deemed necessary. These physicians can provide you and your family with emergency care if hospitalization is needed and ongoing follow-up care. We are happy to communicate and cooperate with your doctor(s) regarding your medical condition(s), options or any other health related issues.

As with many health-related services, there are certain potential complications which may arise during the receipt of these services. Those complications range from discomfort through serious health concerns requiring emergency medical care. The probability of these complications are rare but you are being made aware of the full range of possibilities that may occur and assume the risk of proceeding with care by signing this agreement. I have been informed of alternatives to receiving the health care services proposed in my treatment plan, including no treatment at all, and have agreed to move forward with the proposed plan of treatment. All of my questions have been answered concerning the proposed plan of treatment to my satisfaction.

Our office and its employees make no representations, claims, or guarantees regarding the efficacy of our recommendations. The protocols we recommend are based upon a combination of our clinical experience and knowledge of scientific and medical literature. With this information individualized protocols may be offered and applied as either adjunctive or primary protocols for certain conditions. The undersigned is also expressly notified that some personnel providing services are Nurse Practitioners acting under the supervision and collaboration with a Medical Doctor or Doctor of Osteopathy who may not be physically present but is always available by electronic means.

By signing this informed consent you agree to hold harmless the healthcare provider, its owners, employees and contractors from all professional and personal liability, negligence, or other legal liability. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against us. You have the right to have this consent reviewed by your lawyer before accepting any services from our office and we suggest that you exercise this right.

Our office makes available nutritional supplements and other health related products. You are in no way obligated to purchase these products from our office or any other specific location or company. You may freely choose to purchase such products from any source(s) you wish. The practice may profit from the sale of supplements and other products we make available to our patients.

Most insurance plans cover services that they consider medically necessary and/or reasonable and customary. Many of our services such as regenerative medicine, human cell tissue products, PRP, nutritional consults, exercise programs, dietary protocols and testing (blood/urine/saliva), cold laser therapy, spinal decompression, acoustic wave therapy, PEMF, certain electrical stimulation modalities, vibration therapy, and some injection therapies are often not considered by insurance companies to be necessary or a "covered service" and, therefore, reimbursable, based upon their own criteria. Our office does accept insurance assignment for covered services. I authorize payment of insurance benefits directly to ASJ. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations, testimonial and coordination of care and authorize ASJ to obtain records and communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all cost of my care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, nurse practitioner or therapist, any fees for professional services will be immediately due and payable. By signing this form, you accept full financial responsibility for all non-covered services.

Your signature is being given prior to rendering any services, advice, and/or recommendations whatsoever from the healthcare provider.

It is the responsibility of the patient to follow-up with our office for results of all testing and laboratory procedures. It should not be assumed on the part of the patient that if they are not contacted by our office, or its employees, or if the patient does not schedule or keep consultation, that test results

are normal (or without abnormalities), and may not require further follow ups or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

The patient is further notified that some tests, or all, may not be covered by their insurance company. The patient assumes full responsibility for the costs of non-covered tests. The practice does not assume responsibility for costs of non-covered tests.

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities, electrical stimulation, traction, spinal decompression, manual therapy, therapeutic exercise, and diagnostic x-rays as deemed applicable by my treating doctor. The chiropractic treatment may be performed by the Doctor of Chiropractic and/or other licensed Doctors of Chiropractic working at this clinic or office and/or a licensed Chiropractic Assistant. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as back up for the Doctor of Chiropractic. I have had the opportunity to discuss with the Doctor of Chiropractic or other licensed healthcare provider, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all. I understand, and I am informed that, there are some risks to chiropractic examination and treatment. I have discussed this with the licensed chiropractor, they have answered all of my questions, and my signature below provides my consent for such treatment.

I request and consent to the performance of occupational therapy services, including various modes of physical modalities, electrical stimulation, traction, spinal decompression, manual therapy, therapeutic exercise, taping and strapping as deemed applicable by my treating healthcare provider. The occupational therapy may be performed by a New Jersey licensed Occupational Therapist certified by the New Jersey Board of Occupational Therapy. Occupational therapy may also be performed by an Occupational Therapist who is serving as back up for the Occupational Therapist.

Soreness: I am aware that, like exercises, it is common to experience muscle soreness and possible increased pain in the first few treatments.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormalities are detected this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare but can occur.

Physical Therapy and Lipo-Laser Risks: Some of the therapies used in this office generate heat and electricity and may rarely cause a burn. Despite precautions, if a burn is obtained there will be a temporary increase of pain and possible blistering. This should be reported to the doctor or therapist. Examination procedures have been performed on me to minimize the risk of complications from treatment, and I freely assume these risks.

I request and consent to the performance of medical services rendered by a nurse practitioner licensed in the State of New Jersey. I understand that our nurse practitioner may use IV and injection treatment to treat certain conditions. These treatments involve the use of needles. The risks, although limited, include: puncturing organs in the abdomen or chest cavities, pain, discomfort, infection, or other health issues. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments. I have also been explained the alternatives to this treatment, including no treatment at all, and voluntarily wish to receive this treatment. I have discussed this with the licensed Nurse Practitioner they have answered all of my questions, and my signature below provides my consent for such treatment.

The practice also recommends that you get medical clearance from your MD before you partake in any of the exercise modalities we might suggest. The practice does not allow their sessions with any patient to be recorded on any kind of device, if a patient wants to record a session the practice has to give its consent.

By entering your signature below you are acknowledging that you have read this entire agreement, understand all terms, verbiage (language) and concepts herein, and agree to proceed with care. By signing below you agree that you have weighed the risks and benefits of proceeding with the services and have decided that it is in your best interest to obtain the services proposed. Having been informed of the potential risks, I hereby give my consent or the consent of the minor to which I am legal guardian for said services.

I understand this consent agreement and have executed it freely and willingly.

PRACTICE REQUIRES 24 HOURS NOTICE UPON CANCELLING AN APPOINTMENT. IF PRIOR NOTICE IS NOT GIVEN, YOU WILL BE CHARGED THE FEE ASSOCIATED WITH THE SCHEDULED APPOINTMENT. SIGNING THIS AGREEMENT CONFIRMS YOUR CONSENT TO THESE TERMS.

Patient Name: ____ Patient Date of Birth: ________________

Signature (☐ self ☐ parent or legal guardian): _______________________________ Date: _____________________________

Parent or Legal Guardian Name (if applicable): ____

Witness: ____ Date: _____________________________