

### Patient Intake Form

Date: \_\_\_\_\_  
Acct: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-Mail address: \_\_\_\_\_ Age \_\_\_\_\_ D.O.B. \_\_\_\_\_ Race \_\_\_\_\_  
Sex: Male/ Female  
Marital: M S W D Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Office Phone \_\_\_\_\_  
Name of Emergency Contact \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Family Medical Doctor \_\_\_\_\_ Referred By: \_\_\_\_\_

Are your present problems due to an injury?  Yes  No Enter the date of the injury: \_\_\_\_\_  
Was the injury?  Job Related  Auto Accident  Personal Injury  Other: \_\_\_\_\_  
Did you see any other doctors for this condition?  Yes  No Name of Doctor: \_\_\_\_\_

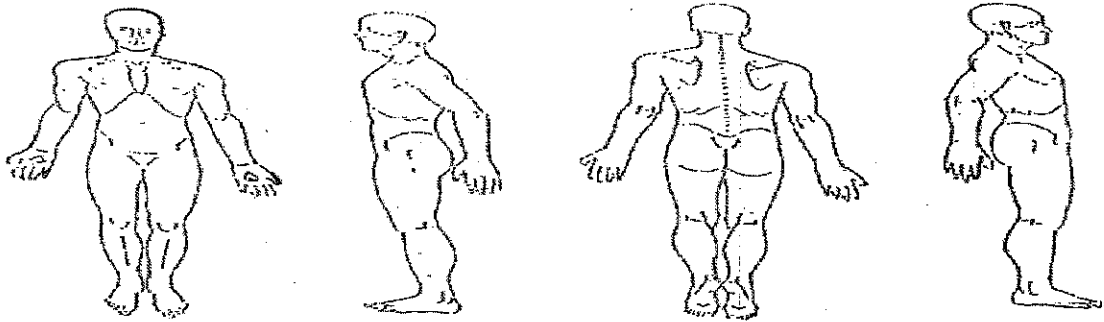
**Goals in your Health are very Important, we want to make sure that we meet your needs**

During the last year, what specific positive or negative events affected your health?  
\_\_\_\_\_  
What are your hobbies? \_\_\_\_\_  
What do you love to do that your current health is preventing your from doing? \_\_\_\_\_  
If you could have perfect health, what would that look like? \_\_\_\_\_  
How does your health challenges affect your significant other or family? \_\_\_\_\_

**List symptoms you are experiencing today:** Choose the severity level associated with each symptom

\_\_\_\_\_  (1) Very Mild  (2)  (3)  (4)  (5)  (6)  (7)  (8)  (9)  (10) Remarkably Severe  
\_\_\_\_\_  (1) Very Mild  (2)  (3)  (4)  (5)  (6)  (7)  (8)  (9)  (10) Remarkably Severe  
\_\_\_\_\_  (1) Very Mild  (2)  (3)  (4)  (5)  (6)  (7)  (8)  (9)  (10) Remarkably Severe  
\_\_\_\_\_  (1) Very Mild  (2)  (3)  (4)  (5)  (6)  (7)  (8)  (9)  (10) Remarkably Severe

**Please mark area(s) of complaint below:**



When, or approximately when did the complaint start? \_\_\_\_\_

Is your condition  Constant  Intermittent (occurs on and off)?

What makes your pain decrease? \_\_\_\_\_

What makes your pain increase? \_\_\_\_\_

Has there been any changes in your bodily functions?  Urination  Defecation  Vision

Respiration  Digestion Other: \_\_\_\_\_

Does your condition affect your daily activities?  Yes  No If yes please explain:

What type of work do you do? \_\_\_\_\_

Are you taking any medications?  Yes  No If yes, which ones?: \_\_\_\_\_

Have you ever had any surgeries?  Yes  No (If yes, please enter the approximate date of surgery.)

Do you have a Pacemaker?  Yes  No

Any unexplained weight loss (more than 10 lbs)  Yes  No

Are you having problems with dexterity? (ex- Has it been more difficult to zip up zipper or button up shirt?)  Yes  No

Are you having only issues with walking/gait?  Yes  No

(ex:Do you walk like a drunken person? Do you feel like you are losing balance?)

Have you ever had any X-rays/MRI/CT or any other images done in the areas in which you are consulting us for?  Yes  No

When/Where? \_\_\_\_\_

Are there any other health issues you would like for like for us to be aware of? (ex. Multiple Sclerosis, Heart Arrythmia, Rheumatoid Arthritis, Ehlers-Danlos syndrome, Marfan syndrome, Lupus, Scleroderma)

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these services to be performed. It is understood and agreed any x-rays and images are for examination only and the x-rays will remain the property of this office.

Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### Patient Financial Responsibility Agreement

Thank you for allowing Hoang Chiropractic Center to assist you with your chiropractic health. In the interest of good health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patient's experience good health, and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible. Payment is due at the time of service. If you have an outstanding balance, you will receive monthly statements with the balance. If you have any questions about your charges or statement, please contact our office at 504-263-2440. The balance of the account is due within thirty (30) days.

**I understand that I am responsible for payment regardless of results or outcome. \_\_\_\_\_(initial)**

I understand that Hoang Chiropractic Center is not a participating provider with my insurance and understand that I am responsible for payment of all fees, charges, cost and expenses incurred in connection with my chiropractic care at Hoang Chiropractic Center. \_\_\_\_\_ (initial)

**Payment is due at the time services are rendered. A 3.95% processing fee applies to debit and credit card payment transactions.**

**The 3.95% fee is waived when paying by ACH, cash or check. \_\_\_\_\_ (initial)**

I the undersigned, (patient name) \_\_\_\_\_ have a claim against a third party for injuries sustained in an accident which occurred on or about \_\_\_\_\_, 20\_\_\_\_. I accept full responsibility for payments of all fees, charges, cost and expenses incurred in connection with my chiropractic care at Hoang Chiropractic Center arising out of the injuries sustained in said accident. I understand Hoang Chiropractic Center is entitled to a privilege or lien under La.R.S.9:4752 on proceeds collected from a third party for services rendered to an injured person or will cooperate with Hoang Chiropractic Center to contact my attorney (if applicable) or auto insurance company for responsibility to pay for chiropractic care rendered.

\*Collection Fees: in the event of failure to pay for the services rendered, I understand that I may be referred to a collection's agency for non-payment of fees due for services rendered by Hoang Chiropractic Center, I understand that I will be responsible for up to 21% collection fee, all agency and attorney fees and cost associated with the collection process and that these fees and cost addition to the collection agency fee. Further, I understand that my PHI will necessarily be revealed in these efforts to collect payment for money owed.

\_\_\_\_\_  
Patient signature or Legal Guardian

\_\_\_\_\_  
Date

**INFORMED CONSENT**  
**HOANG CHIROPRACTIC CENTER**

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, exercise instruction, spinal decompression therapy, etc.

**Strokes:** Strokes are the most serious problem that has been associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. In extremely rare instances chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA, vol.37, June, 1993) estimate that the incident of this type of stroke is 1 per 3,000,000 upper neck adjustments.

**Disc herniation:** Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, spinal decompression therapy etc. This includes both neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, spinal decompression therapy etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause worsening of a pre-existing disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their problem.

**Soft tissue injury:** Soft tissue primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments, traction, massage therapy, spinal decompression therapy, etc., may tear some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments of resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

**Rib fractures:** The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

**Physical therapy burns:** Some of the machines we use generate heat. We also us both heat and ice and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely either heat or ice can burn or irritate the skin. The results is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

**INFORMED CONSENT  
HOANG CHIROPRACTIC CENTER**

**Soreness:** It is common for chiropractic adjustments, traction, massage therapy, exercises, spinal decompression therapy etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

**Matrix:** The risks and possible complications of this treatment which include, but are not limited to, failure of the procedure to eliminate the pain headaches, muscle cramping, itching, skin burns, (possible blistering), at site of application, nausea, vomiting and in women, the possibility change in the menstrual cycle.

**Other problems:** There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment at this office. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

I voluntarily consent to the performance of chiropractic examination, manipulation and other chiropractic procedures, on myself (or on the patient named below, for whom I am legally responsible) by said Chiropractor (see below), his/her preceptor(s), and/or other licensed doctors of Chiropractic who now or in the future provide Chiropractic treatment for me. This consent includes other doctors of Chiropractic that are employed by, associated with, or serve as back-up for said Chiropractor, whether or not their names are listed on the form. I understand that the results from the Chiropractic treatment are not guaranteed for my condition. The doctor has discussed the goals and potential benefits of proposed treatment, other alternative types of treatment for my condition and associated risks by having Chiropractic examination and procedures. I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to the recommended Chiropractic treatment over the entire course of treatment for my present condition and any further conditions for which I seek treatment. All of the questions concerning this care and treatment have been answered to my satisfaction.

X \_\_\_\_\_

Signature of Patient or Responsible Party

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor)

OFFICE WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**HOANG CHIROPRACTIC CENTER**

2120 Belle Chasse Hwy. Gretna, LA 70053- office 504-263-2440/ fax 504-263-2442  
3848 Veterans Blvd. Ste 104 Metairie, LA 70002- office 504-941-7139/fax 504-941-7643

Hoang Chiropractic Center  
2120 Belle Chasse Hwy  
Gretna, Louisiana 70053  
PH: 504-263-2440

Hoang Chiropractic Center  
3848 Veterans Blvd. Suite 104  
Metairie, La. 70002  
504-941-7139

### **Notice of Patient Privacy Policy**

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice, please contact our Privacy Officer or any staff member in our office. Our Privacy Officers are Jessica Leblanc in Gretna and Brenna Shea in Metairie.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website [www.hoangchiro.com](http://www.hoangchiro.com), calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

#### **A. Uses and Disclosures of Protected Health Information**

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

#### **Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent**

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to, to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of students.

For example, we may disclose your protected health information to interns or preceptors that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

#### **Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

##### **1. Confidentiality of Reproductive Health Information:**

Our practice is committed to protecting the privacy and confidentiality of your reproductive health information. This includes information related to fertility treatments, prenatal care, contraception counseling, and abortion services. We have implemented strict safeguards to ensure that your reproductive health data is always kept secure and confidential.

##### **2. Access to Reproductive Health Records:**

You have the right to access and obtain copies of your reproductive health records maintained by our practice. These records will only be released after obtaining a specific and separate release of reproductive rights protected information signed by the patient, except where required by law. If you wish to review or receive a copy of your fertility treatment history, prenatal care notes, contraception counseling records, or abortion services documentation, please contact our privacy officer to initiate the special request and authorization for such.

### 3. Non-Discrimination and Respect for Reproductive Choices:

Our practice upholds a policy of non-discrimination. We respect and support your reproductive choices, regardless of factors such as age, gender identity, sexual orientation, marital status, or individual preferences. Your reproductive health records will be honored and respected by our healthcare team.

### 4. Disclosure of Reproductive Health Information:

We will only disclose your reproductive health information to authorized individuals or entities as permitted by law and with your explicit consent. Your reproductive health data will not be shared with third parties without your permission. We require a special authorization, above and beyond a simple standard release form, to release any reproductive care documentation, except in cases where disclosure is required by law or for purposes of treatment, payment, or healthcare operations.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

### Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information

include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.
- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

#### B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor. You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form.

Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.
- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.
- **You have the right to be notified by our office of any breach of privacy of your Protected Health Information.**
- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

### C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to: <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html> -- Or our office can provide you with a written form in which to file your complaint.* You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. Our Privacy Officer is Jessica Leblanc. You may contact our Privacy Officer or any staff member, including Veronica Nguyen, at the following phone number: 504-263-2440 or on our website: [www.hoangchiro.com](http://www.hoangchiro.com) for further information about the complaint process.

This notice was published and becomes effective on March 1, 2025

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Hoang Chiropractic Center  
Metairie-Gretna Disc Centers of America  
Recording Consent**

I hereby authorize Hoang Chiropractic Center to obtain and use, for purposes of training, education, and employee evaluation, the video recording of my consultation and/or examination, including but not limited to images and discussions of all aspects of my health care and spinal condition.

I understand that the training, education and employee evaluation may be conducted by the practice and that recordings may be viewed by clinicians and non-clinicians associated with the practice.

This release shall not be construed to grant broad authority for use in advertisements, marketing, or other public broadcasts unless authorized in writing by both parties.

I understand the video recording of my consultation and/or examination will involve disclosure of my health information. I understand that my name, personal health information, disclosed during the consultation or examination may be viewed by others.

I understand that recordings may include images, statements and other events that may occur during my consultation or examination, including information disclosed regarding drugs and alcohol abuse, psychiatric illness, and HIV or other communicable diseases.

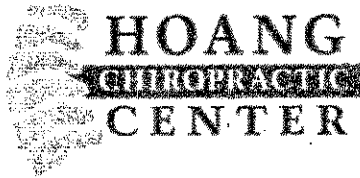
While the Practice employs industry standard practices to ensure the privacy of the recordings, (is of an encrypted connection, individual account names and passwords, secure server access), I understand the privacy of my confidential personal health information on my videos cannot be guaranteed.

My authorization for the Practice to use the information obtained does not relieve the Practice of obligations other than those specifically identified in this authorization.

I understand I have the right to revoke this authorization at any time by sending written notification to the Practice. Any revocation will not be effective to the extent the price or have taken action in reliance on this authorization. This authorization is valid for one (1) year from the date of consent unless otherwise revoked.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



#### **NEUROMED MATRIX / ELECTROANALGESIA INFORMED CONSENT**

I am aware and my family has been informed, at my request, of the diagnosis of my condition and the recommended treatment. I and my family request this attending physician to perform the treatment indicated below on me. I and my family have been advised and are aware of the risks and possible complications of this treatment which include, but are not limited to, failure of the procedure to eliminate the pain, headaches, muscle cramping, itching, skin burns, (possible blistering), at site of application, nausea, vomiting and, in women, the possibility of temporary change in the menstrual cycle. I hereby request that Disc Centers of America to perform Neuromed Matrix/ Electroanalgesia Therapy.

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Patient Signature

Date

#### **INFRARED LASER THERAPY INFORMED CONSENT**

I am aware and my family has been informed, at my request, of the diagnosis of my condition and the recommended treatment. I and my family request this attending physician to perform the treatment indicated below on me. I and my family have been advised and are aware of the risks and possible complications of this treatment which include, but are not limited to, damage of retina if not using proper protective eyewear, temporary increase of pain during application of therapy or the day following therapy, mild bruising from vasodilation, temporary dizziness, or reactions when also using photosensitizing drugs. Possible adverse effects from laser therapy are normally rare and temporary but may occur from hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from probe, and laser over-stimulation. I hereby request that Disc Centers of America to perform Infrared Laser Therapy.

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Patient Signature

Date

#### **DRY NEEDLING INFORMED CONSENT**

I am aware and my family has been informed, at my request, of the diagnosis of my condition and the recommended treatment. I and my family request this attending physician to perform the treatment indicated below on me. I and my family have been advised and are aware of the risks and possible complications of this treatment which include, but are not limited to, post-needling soreness, risk of infection due to breaking the skin, bruising, and prickling or zinging sensation. When needling the thorax, there is a very small risk of the needle coming in contact with lung tissue causing a pneumothorax; great care is taken to avoid this area. Possible complications from dry needling therapy are extremely rare and often temporary; precautions will be taken to avoid them. I hereby request that Disc Centers of America to perform Dry Needling Therapy.

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Patient Signature

Date

**EXTRACORPOREAL SHOCKWAVE THERAPY / SOFTWAVE THERAPY INFORMED CONSENT**

I am aware and my family has been informed, at my request, of the diagnosis of my condition and the recommended treatment. I and my family request this attending physician to perform the treatment indicated below on me. I and my family have been advised and are aware of the risks and possible complications of this treatment which include, but are not limited to, pain and soreness. The FDA has labeled this a "Non-Significant Risk". I have been fully informed of EWST's use, which has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirm that I have been given the opportunity to discuss and clarify any concerns. I understand there is no guarantee for pain relief or improvement of function. I understand that foregoing treatment is not the first option for my condition and an alternate treatment has already been offered or provided to me. I hereby request that Disc Centers of America to perform EWST/Softwave Therapy.

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Patient Signature

Date

**STIMPOD INFORMED CONSENT**

I am aware and my family has been informed, at my request, of the diagnosis of my condition and the recommended treatment. I and my family request this attending physician to perform the treatment indicated below on me. I and my family have been advised and are aware of the risks and possible complications of this treatment which include, but are not limited to, skin irritation or burn. I hereby request that Disc Centers of America to perform Stimpod Therapy.

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Patient Signature

Date

**GENERAL CONDITIONS**

By initialing, I confirm that I have no **history of epilepsy or stroke.**

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By initialing, I confirm that nothing is **implanted in my body.**

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By initialing, I confirm that I do not take **blood thinners/ have a bleeding disorder.**

\_\_\_\_\_

By initialing, I confirm I do not have **low blood pressure.**

\_\_\_\_\_

By initialing, I confirm I do not take **immune suppressant medications.**

\_\_\_\_\_

By initialing, I confirm that I have not been **injected with cortisone this month.**

\_\_\_\_\_

By initialing, I confirm that I do not use a **cardiac pacemaker.**

\_\_\_\_\_

By initialing, I confirm that I do not have **cancer or any tumors.**

\_\_\_\_\_

By initialing, I confirm I do not have a **known skin infection.**

\_\_\_\_\_

By initialing, I confirm I am not **pregnant.**

\_\_\_\_\_