Natural Health Medical Center, Inc.

Huy Hoang, M.D., Internal Medicine

PATIENT REGISTRATION

NAME: **DATE OF BIRTH:**

ADDRESS: **HOME #: ( ) -**

CITY, STATE, ZIP: **WORK #: ( ) -**

EMPLOYER: **FAX #: ( ) -**

SPOUSE/SIG. OTHERS:

EMERGENCY CONTACT: OTHER THAN SPOUSE

NAME: **PHONE:** **RELATION:**

EMAIL:

SSN: **DRIVER'S LIC.#:**

REFERRED BY:

BILLING INFORMATION & INSURANCE

PRIMARY INSURANCE:

CLAIMS ADDRESS:

SUBSCRIBER'S NAME: **ID#:**

EFFECTIVE DATE: **GROUP #:**

SECONDARY INSURANCE:

CLAIMS ADDRESS:

SUBSCRIBER'S NAME: **ID#:**

EFFECTIVE DATE: **GROUP #:**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Hoang to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits for payment of services rendered.

RESPONSIBILITY & ASSIGNMENT OF INSURANCE BENEFITS

All professional services rendered will be charged to the patient. All necessary billing information will be provided to help expedite insurance carrier reimbursement payments. However, the patient will be responsible for all fees incurred regardless of insurance coverage payment for all services rendered is customarily due at the time of service unless special arrangements may be made with our office bookkeeper in advance. I hereby authorize direct payment of surgical/medical benefits to Dr. Hoang for services rendered by him in person or under supervision.

PATIENT SIGNATURE & DATE

I acknowledge that the above information is true and I understand the information written above.

PATIENT SIGNATURE **DATE**

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

AAC-CA

Natural Health Medical Center, Inc.
Huy Hoang, M.D., Internal Medicine

INFORMED CONSENT

Some of our approaches are considered complementary medicines, which do not claim to cure any diseases, and they help to complement your conventional treatments. You are encouraged to seek different opinions and options. Dr. Hoang does not do hospital work, so you will need a physician for emergency or hospital care.
I have read the above and I am fully responsible to make my own decisions. In addition, on this and any subsequent visit, I am here solely on my own behalf and not as an agent for federal, state or local agencies on a mission of entrapment or investigation.

Signature of Pt./Name printed | Signature of witness/Name printed | Date

INSURANCE BILLING
If laboratory specimens are sent to a non-preferred provider laboratory, I am fully responsible for the balance of the bill from the laboratory.

Signature of Pt./Name printed | Signature of witness/Name printed | Date

ACUPUNCTURE
Acupuncture involves the use of very fine sterile needles inserted into certain points of the body to balance the energy channels.
Potential Benefits: may help to balance the energy channels of the body.
Potential Side Effects: possible dizziness and sweating due to apprehension, local pain, bleeding and inflammation, damage to certain tissues like nerves and organs, and rarely death.
This approach does not claim to cure any diseases. I have been informed about the potential benefits and side effects and I have decided to undergo the treatment.

Signature of Pt./Name printed | Signature of witness/Name printed | Date

BLOOD DRAWS
Potential Side Effects: possible dizziness and sweating due to apprehension, local pain and bleeding.

Signature of Pt./Name printed | Signature of witness/Name printed | Date

INTRAMUSCULAR (IM) INJECTIONS AND INTRAVENOUS (IV) THERAPIES
Potential Benefits:
IM/IV: vitamin/mineral/homeopathic therapies may help improve energy and nutritional status
EDTA: approved for the treatment of heavy metal toxicity, not approved for the treatment of circulation disorders but may help the symptoms.
DMPS: considered experimental for the treatment of Mercury toxicity.

Potential Side Effects:
Possible dizziness and sweating due to apprehension, local pain, bleeding and inflammation, bruising, damage to certain tissues like nerves and organs, allergic reaction, hypoglycemia, hypocalcemia and kidney damage (EDTA and DMPS), fatigue, depression and rarely death.

These approaches do not claim to cure any disease. I have been informed about the potential benefits and side effects and I have decided to undergo the treatments.

Signature of Pt./Name printed | Signature of witness/Name printed | Date

REFUND POLICY ON SUPPLEMENTS
Once a bottle is opened, unless the pills are defective, NHMC is unable to refund or give you credit because the bottle cannot be given to another patient. If the bottle is not open, NHMC will give you credit that you can use for the future rather than a refund.

Signature of Pt./Name printed | Signature of witness/Name printed | Date

MINOR SURGICAL PROCEDURE
Risks: pain, allergic reaction to anesthetic, and bleeding.

Signature of Pt./Name printed | Signature of witness/Name printed | Date

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COMPREHENSIVE HISTORY

NAME: _____ **DATE**: _____

AGE: _____ **OCCUPATION**: _____

The following questions refer to both the past and the present time. For example, for the question "Do you smoke?", if you smoked before but quitted, then you should answer "Yes, before"

PRESENT MAJOR PROBLEMS	FOR HOW LONG	DESCRIBE

If you have a weight problem, Your highest weight _____ Your lowest weight _____

Please list your previous treatments Doctors

PAST HISTORY

Medical History Date

Surgical History Date

Childhood Illnesses

FAMILY HISTORY

Medical Problems Relatives

MEDICATIONS

Please list all the medications Dosage How many times a day

Do you use recreational drugs? _____ What type? _____

SUPPLEMENTS

ALLERGY

To what drugs _____ What happened? _____

To what foods _____ What happened? _____

AIR

Y N Do you smoke? How much?_____How many years?_____
Y N Do you live or work with people who smoke?
Y N Do you have an air filter at home or at work? What type?_____
Y N Do you have plants at home or work? What type?_____
Y N Do you do breathing exercises? What type?_____
Y N Do you breath better after a rain?
Y N Do you feel sleepy when in a closed moving car?

WATER

How much liquids do you drink a day?_____
Y N Do you drink tap water?
Y N Do you drink bottled water? What type?_____
Y N Do you have a sink filter? What type?_____
Y N Do you have a shower filter? What type?_____
Y N Do you drink coffee or decaff?
Y N Do you drink tea? What type?_____
Y N Do you drink alcohol? How much?_____
Y N Do you drink sodas? How much?_____
Y N Do you drink fruit juice? How much?_____
Y N Do you drink vegetable juice? How much?_____
Y N Do you swim in chlorinated swimming pools?

FOODS	Days	per week	per month
Y N Do you eat organic foods?			
Y N Do you eat a special diet?	What type?_____		
Y N Do you eat fish?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat chicken?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat red meat?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat pork?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat eggs?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat seafoods?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat nuts?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat soybean products?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat vegetables?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat fruits?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you drink milk? What type?_____	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat rice?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat grains?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat sugar? What type?_____	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat white flour?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat margarine?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat junk foods?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat canned foods?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat fast foods?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat microwave foods?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you eat fried foods?	How often?	7 6 5 4 3 2 1	3 2 1
Y N Do you use oils to cook?	What type?_____		
Y N Do you use salt?	What type?_____		
Y N Do you eat in a hurry?	Why?_____		
Y N Do you eat after 8 pm?			

What is your biggest meal in a day?_____
Y N Do you drink while eating?
Y N Do you chew gums?
Y N Do you use Nutrasweet?
List foods that you eat more than 3 times a week_____
List you food cravings Sweets?____Starch?____Greasy foods?____Salty foods?____Spicy foods?____
How often do you eat at home?_____In restaurants?_____What type?_____
List you typical schedule in a day
Wake up at ____ Exercise at_____ Breakfast at_____ Lunch at_____ Dinner at_____Sleep at _____
List typical foods at each meal B_____ L _____ D _____ Bedtime _____
List your bad eating habits No time to eat?____ Eat too late?____ Chew too few times?____

HEAVY METAL EXPOSURE

Y N Do you use aluminum cookware or aluminum foil?
Y N Do you have copper water pipe?
Y N Do you have amalgam/mercury/silver fillings?
Y N Do you have body implants? What type?_____
Y N Do you have other chemical exposure? What type?_____

ELECTROMAGNETIC EXPOSURE

Y N Do you live near power lines?
Y N Do you use electric blankets?
Y N Do you wear a beeper?
Y N Do you work with a computer? How often?_____ How far from screen?_____
Y N Do you watch TV? How often?_____ How far from screen?_____
Which direction does your head point when you sleep? North? ____ East? ____ South? ____ West? ____
Y N Do you use full-spectrum light?
How much sunshine do you get in a day? _____

EXERCISE

Y N Do you exercise? How often?_____What type?_____
How many hours do you walk a day?_____

PSYCHO-SOCIAL-SPIRITUAL FACTORS

What is the most important value in you life? Rate 10 as most important and 0 as not important
Health?___ Work?___ Money?___ Family?___Spouse?___ Self?___Friends?___Pleasure?___Church? ___
Who do you live with?_____
Y N Do you have stress at work?
Y N Do you have stress at home?
Y N Do you have financial stress?
How do you deal with stress? Exercise? ___ Reading? ___ Music? ___ Hold it inside? ___ Tell others? ___
Y N Do you meditate? What type? _____
List you hours of sleep _____
Y N Do you have insomnia? Falling asleep? ____ Waking up in the middle? ____ Waking up early? ____
Y N Do you have depression?
Y N Do you have anxiety?
Y N Do you pray?
Y N Do you believe in a higher being?
Y N Do you believe in past life?

DENTAL HEALTH

How many times a day do you brush? ____ What type of toothpaste? _____
Y N Do you have toothache? Which tooth? _____

SEXUAL HISTORY

What is your sexual orientation? With the opposite sex? ____ With the same sex? ____
Y N Are you sexually active? How often? _____ With someone you know? _____
Y N Do you wear protection? What type? _____
Y N Do you use birth control pills? How long? _____What type? _____

OVERALL FACTORS

What do you think the main cause(s) of your health problems is (are)?
Mental stress? ___ Emotional stress?___ Suboptimal nutrition?___ Inactivity? ___ Toxic environment? ___

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4469 Redondo Beach Blvd, Lawndale, CA 90260
(310) 479-2266/479-2044 (fax)

OFFICE POLICIES

Medicare reimbursement

- Dr Hoang is a non-participating Medicare provider. That means that Medicare will send the checks to the patients so we ask the patients to pay first, then we bill, then Medicare will send the patients a check few weeks later.
- We don't bill the 2nd insurance because Medicare will automatically send the billing information to the 2nd. Most of the times, the 2nd will send the checks to the patient. Rarely, some 2nd insurances will send to us, and we will give the credits back to the patients.

Blue Shield reimbursement

- Dr Hoang is out of network. Therefore, Blue Shield will send the checks to the patients.
- We ask that you pay first, then we bill, then Blue Shield will send the checks a few weeks later.

Test results

- If the test results are normal, you will be notified that they are normal and you don't have to come in.
- If the test results are not normal, you will be asked to come in for follow up. You can do a phone consultation and the fee is the same as an office visit.

Questions

- If you have a simple question, you can leave a message for Dr. Hoang or email to patient@naturalhealthmc.com and he will get back to you within 24 hours. If he does not, please call or email back to remind him.
- If you have more than one question, please make an appointment.

Cancellation

- Please call us if you are not able to make the appointment.
- If cancel within 24 hours, there will be a charge equal to the visit.

_____ _____ _____

Patient's signature Patient's name Date