For Office Use

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

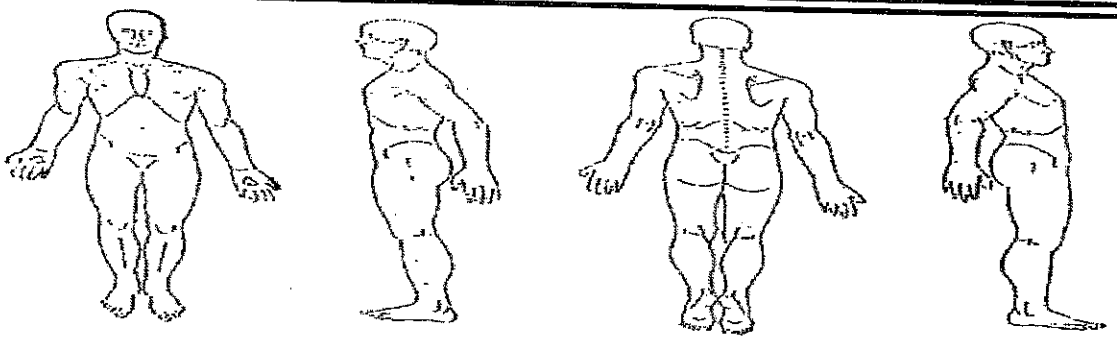
During the last year, what specific positive or negative events affected your health?

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 reveled 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 hear 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 severe 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, 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 precepts 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 patent, 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.

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 breech 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 for further information about the complaint process.

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

Signature _____

Date _____

HOANG CHIROPRACTIC CENTER

DISC CENTERS of AMERICA™ METAIRIE-GRETNA

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.

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.

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.

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.

_____

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.

_____

Patient Signature Date

GENERAL CONDITIONS

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

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

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.** _____

CareCredit

APPLICATION AND CREDIT CARD ACCOUNT AGR ...NT

Credit is extended by Synchrony Bank.

For providers, (800) 859-9975 or CAR... For patients/clie...

Submit the application: ...DIT.COM/PROVIDERCENTERLOGIN ...800) 365-8295 or CARECREDIT.COM

ESTIMATED FEE $	Office Merchant #		Pre-Approval Offer ☐ Accepted ☐ Refused Date ____	ID verified (initial):
Applicant ID Type ☐ Driver's License ☐ State Issued ☐ Federal Government	Issuance State	Exp. Date	Joint Applicant ID Type ☐ Driver's License ☐ State Issued ☐ Federal Government	Issuance State / Exp. Date
Provided by Synchrony Bank:	Account #	Authorization # or Key #	Approved Credit Limit	

NOTICE: This is an application for a CareCredit credit card account issued by Synchrony Bank ("SYNCB"). If SYNCB does not approve you for a CareCredit credit card, it may use the application information you provided to consider you for other financing products we offer. You also direct SYNCB or your provider/retailer to share all of your application information, on your behalf, with other lenders in connection with your desire to obtain financing. You authorize such lenders to obtain one or more consumer reports about you, including to determine whether you may be prequalified for loan products they offer. The rates, fees, and other credit terms provided with this application apply only to the CareCredit credit card account issued by SYNCB. Other financing products may have different rates, fees, and terms. Notwithstanding the foregoing, SYNCB and your provider/retailer have no obligation to share your application information.

1. APPLICANT INFORMATION: Please tell us about yourself. Except as noted below, you must reside in the United States and be 18 years or older to apply.

Name (First-Middle-Last) Please Print	Date of Birth / /	Social Security Number/ITIN - -	Primary Phone Number * ( )
Mailing Address Apt.# City State ZIP			Other Phone Number * ( )
If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. Contact Person Name Street Address (Street Name and Number) ☐ Your Address? City State ZIP ☐ Contact Person?			
Email Address (optional)	Housing Information ☐ OWN ☐ RENT ☐ OTHER	Monthly Net Income From All Sources** $	Business/Work Phone Number* ( )

2. JOINT INFORMATION: An additional card will be issued to the person indicated below. The applicant (and joint applicant, if any) will be liable for all transactions made on the account including those made by any authorized user. JOINT APPLICANT: You agree that we may send notices to you and/or applicant at the applicant's address, regardless of whether you live at that address.

Name (First-Middle-Last) Please Print	Date of Birth / /	Social Security Number/ITIN - -	Primary Phone Number * ( )
Mailing Address Apt.# City State ZIP			Other Phone Number * ( )
If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. Contact Person Name Street Address (Street Name and Number) ☐ Your Address? City State ZIP ☐ Contact Person?			
Email Address (optional)	Housing Information ☐ OWN ☐ RENT ☐ OTHER	Monthly Net Income From All Sources** $	Business/Work Phone Number* ( )

*You authorize Synchrony Bank to contact you at each phone number you have provided. By providing a cell phone number you agree to receive 1) account updates and information and 2) account security alerts, including text messages from Synchrony Bank. Message frequency varies. Message and data rates may apply. Text HELP for help, text STOP to Opt-Out. Terms and Conditions and Privacy Policy: www.synchrony.com.

Your "Net Income" includes what you earn or reasonably expect to earn from employment, investments, retirement, social security benefits and public assistance. You can also include money that someone else deposits regularly into your account (individual or joint) and the amount that you have available to spend from your assets. If you are 21 or over, you may also include the amount of someone else's income that is regularly used to pay your expenses. Alimony, child support or separate maintenance income need not be included unless relied upon for credit. **WI Residents Only: If this is an individual account, please also include your spouse's income.

3. APPLICANT and JOINT APPLICANT: We need your signature(s) below.

I ask Synchrony Bank ("SYNCB") to issue me a CareCredit Credit Card (the "Card"), and I agree:

- To the CareCredit Credit Card agreement ("Agreement").
- I am providing the information in this application to SYNCB, CareCredit LLC, and providers that accept the Card and program sponsors (and their respective affiliates), and I consent to SYNCB's providing information about me to CareCredit LLC, and providers that accept the Card and program sponsors (and their respective affiliates) for their own business purposes.
- SYNCB may obtain credit reports and other information, including employment and income, about me to evaluate my application and for other purposes.
- SYNCB, and any other owner or servicer of my account, may contact me about my account, including through text messages, automatic telephone dialing systems and/or artificial or prerecorded voice calls for informational, servicing or collection related communications, as provided in the Address/Phone Change and Consent To Communications provisions of the Agreement. I also agree to update my contact information.
- The Agreement will govern my account and: **(1) includes a Resolving a Dispute with Arbitration provision that limits my rights unless: (a) I reject the provision by following the provision's instructions or (b) I am covered by the Notice for Active Duty Military Members and their Dependents set forth in the Agreement;** and (2) makes each applicant responsible for paying the entire amount of credit extended.
- **Authorization for the Social Security Administration to Disclose Your Social Security Number Verification.** I authorize the Social Security Administration (SSA) to verify and disclose to SYNCB through SentiLink Verification Services Corp, SYNCB's service provider, for the purpose of this transaction whether the name, Social Security Number (SSN) and date of birth I have submitted matches information in SSA records. My consent is for a one-time validation within the next 90 days.
- **Applicants applying for credit arranged by a provider in California only:** I have received and signed a notice that I received from my provider entitled "Credit or Loan for Health Care Services."

PLEASE SEE NEXT PAGE FOR RATES, FEES AND OTHER COST INFORMATION.

Federal law requires SYNCB to obtain, verify and record information that identifies you when you open an account. SYNCB will use your name, address, date of birth, and other information for this purpose.

If I have been pre-approved, I request that you open the type of account for which I was pre-approved. I have read the Prescreen Disclosures, credit terms and other disclosures on the next pages and have been provided my credit limit applicable to the account. SYNCB reserves the right to refuse to open an account in my name if SYNCB determines that I no longer meet SYNCB's credit criteria or if I do not have sufficient income. If you apply with a Joint Applicant, each of you will be jointly and individually responsible for obligations under the Agreement and by signing below, you each agree that you intend to apply for joint credit.

Signature of Applicant	Signature of Joint Applicant (If Applicable)
X_____ Date_____	X_____ Date_____
(Please Do Not Print)	(Please Do Not Print)

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PLEASE READ THE CARECREDIT CREDIT CARD ACCOUNT AGREEMENT BEFORE SIGNING THIS APPLICATION.