State of Louisiana Board of Chiropractic Examiners

8621 Summa Avenue, Baton Rouge, LA 70809

Phone: 225-765-2322 / Fax: 225-765-2640 / Email: lsbce@eatel.net

The Louisiana Board of Chiropractic Examiners does not accept anonymous complaints. Please include your contact details.

COMPLAINT FORM

Instructions: Please print clearly using blue or black ink. Complete all sections as thoroughly as possible. Sign and date the Authorization and Release section at the end of this form. You may submit this completed form and any supporting documents by **mailing** them to the physical address above or by **scanning and emailing** them to lsbce@eatel.com. Incomplete forms may delay or prevent an investigation.

COMPLAINT FILED AGAINST		
Name of Chiropractor:		
Address:		
City:	**State:**	**Zip Code:**
Business Phone Number:		

PERSON FILING COMPLAINT		
Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Business Phone:**	
E-Mail:		

PATIENT OR PERSON INVOLVED IN THE INCIDENT:
Name:
Date of Birth (m/d/yyyy):

Date Received

BOARD OFFICE USE ONLY

Complaint # Issued _____

Complaint Reviewed By: _____

_____

Details of Complaint:

Describe your complaint in detail and the events that led to it. Include specific dates, location of treatment, therapies prescribed or used. You may use additional paper or submit other documents to clarify the information given. (*See* attached Records Release Form for complaints involving billing or quality of care issues).

Second Opinion:

Have you received a second opinion from another healthcare provider? Yes:_____ No:_____

If yes, please give full name and address.

Healthcare Provider Name:

Address:

City/State/Zip:

I acknowledge that the information I have submitted above in this form is to be true and accurate. If my complaint is more appropriately addressed by a different agency or entity, I authorize the Board to forward my complaint to that agency or entity. I understand if I do not provide the information necessary to conduct an investigation that this complaint will not be processed.

Signature **Date**

Complete and Send Email, Mail or Fax

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Records Release Form

I,_____ , hereby authorize Dr._____
and any other health care provider that has provided health care to me in connection with the treatment that is the subject of this complaint or any complications rising there from, to provide the Louisiana Board of Chiropractic Examiners or its authorized representatives, any and all information relevant to me or my dependent's physical condition, treatment records, billing records, which may be requested including but not limited to reports, evaluations, x-rays or other diagnostic tools, prescriptions, progress notes, order sheets, admission forms, laboratory reports, nurses reports and consultation reports for:

_____ _____
Patient's Name Patient's Date of Birth

I understand that the information released will be part of the Board's investigative file and I agree that a photocopy of this authorization and signature has the same force and effect as the original.
The authorization is limited in neither time nor medical subject area.
This authorization shall act as a revocation of all releases provided to the Board involving the subject matter of this release which I may have signed prior to the effective date here.

_____ _____
Signature of Authorizing Person Date