RACHEL WEST, D.O.
CONTEMPORARY MEDICINE

12300 WILSHIRE BLVD., SUITE 420 • LOS ANGELES, CA 90025
TEL: (310) 450-8959 • FAX (310) 450-8342 - WWW.DRRACHELWEST.COM

NEW PATIENT INFORMATION FOR MEDICAL RECORDS

NAME: _____ **DOB:** _____-_____-_____ **SEX**: __ M __ F
SOCIAL SECURITY #: ___-__-____ **PRIMARY LANGUAGE:** _____
RACE: ___ CAUCASIAN ___ AMERICAN INDIAN ___ASIAN ___BLACK/AFRICAN AMERICAN ___ DECLINED ___ NAT. HAWAIIAN/PACIFIC ISLANDER ___ UNKNOWN ___ OTHER

DOES THE PATIENT SMOKE? ___ YES __ NO - **DOES THE PATIENT DRINK ALCOHOL?** ___YES ___NO

ADDRESS: _____**CITY:** _____**STATE:** ____ **ZIP:** _____
CELL #: (___) ____-____ **HOME #:** (___) _____-____ **WORK #:** (___) ___-___

IF APPLICABLE (=you are a parent/caregiver/friend): RELATIONSHIP TO PATIENT: _____
YOUR EMAIL: ***YOUR PHONE #:***

Please indicate which number we can leave confidential information: □ CELL □ HOME □ WORK
EMAIL: _____ **PREFERRED MEANS OF COMMUNICATION**: _____

YOUR PHARMACY'S CONTACT INFO:_____
WHO MAY WE THANK FOR YOUR REFERRAL? _____

PRIMARY INSURANCE:
INSURANCE NAME: _____
INSURANCE ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
INSURANCE TELEPHONE #: _____
SUBSCRIBER ID # _____
GROUP # _____ POLICY HOLDER: _____
DOB: _____ SOCIAL SECURITY#: _____

SECONDARY INSURANCE:
INSURANCE NAME: _____
INSURANCE ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
INSURANCE TELEPHONE NUMBER: _____
SUBSCRIBER ID # _____
GROUP # _____ POLICY HOLDER: _____
DOB: _____ SOCIAL SECURITY#: _____

EMERGENCY CONTACTS:
NAME: _____ CONTACT #: _____ RELATIONSHIP: _____
NAME: _____ CONTACT #: _____ RELATIONSHIP: _____

Credit / debit card information is required for cancellation purposes, phone consultations, shipping & handling of orders and outstanding balances in account.
CARD TYPE: _____ VISA _____ MASTERCARD _____ AMERICAN EXPRESS _____
CARDHOLDER NAME: _____ RELATIONSHIP TO PATIENT: _____
CARD NUMBER: _____ EXP. DATE: _____ SECURITY CODE: _____

I certify to my best of my knowledge the above information is correct. I hereby consent to Medical and Osteopathic Treatment by Rachel West, D.O. and the staff of her medical practice.
Appointments not cancelled within 48 hours or no-shows to a scheduled appointment will lead to a 50% charge of the allotted appointment fee on the patient's credit/debit card.

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN): _____

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Pediatric Health History Information

Child's Name: _____DOB: _____Sex: _____

1. What brought you and your child in today?

_____

2. What developmental issues does your child suffer with currently if different from above?

_____

Other Health Issues:

3. Does your child suffer with other health problems?
__ Allergies __ Asthmas __ Constipation __ Diarrhea __ Eczema __ Kidney Problems
__ Lung disease __ Diabetes __ Thyroid Disease __ Heart Disease __ Seizures __ Ear Infections

Other:

_____

4. Did your child's condition change following an illness, infection, and or seizure disorder? Explain:

_____
_____

Digestive Health:

5. Does your child have periodic loose stools or diarrhea? How often and what color?

_____

6. Does your child have gas after eating a certain meal? If yes, what food?_____

7. Does your child have undigested food in his stools? _____

8. Is your child potty trained and at what age? _____

9. Does your child suffer from heartburn or reflux? _____

10. Is your child currently taking and acid blocking medication such as Tagament or Pepcid, etc.?

_____

11. Did your child digestive problems occur following a particular vaccine? Which one?

_____

12. Has your child ever produced formed stools? _____

Antibiotic History:

13. How many courses of antibiotic has your child received in his/her lifetime? Name of antibiotic if known.
_____

14. Main reason for antibiotic use:
___ Ear infection ___ Bronchitis ___ Pneumonia ___ Sinus Infection ___ Intestinal Infection
Other, please
explain:_____
_____

15. Was your child ever treated for yeast or Candida following antibiotic use? _____

Home Environment:

16. How old is your current house/apartment?
_____

17. Has your child lived in a home that had lead based paint?
_____

18. What kind of flooring does your home have? ___ Carpet ___ Wood floors ___ Tile___ Other:
_____

19. Do you use commercial cleaners at home? List them: _____

20. Has your child ever used or currently sleeps with fire resistant clothes or bedding?
_____

21. Is your child exposed to outside pesticides, fungicides, etc.?
_____

22. Please list pets and or farm animals your child is exposed to:
_____

Mother's Pregnancy and Labor:

23. Did the child's mother have any complications during pregnancy? Explain.
_____

24. Does the child's mother know her Rh factor and blood type?
_____

25. Did the mother receive Rhogam medication during her pregnancy?
_____

26. Did the mother receive any vaccinations during pregnancy? If yes, which ones?
_____

27. Did the mother receive any vaccinations after birth when breast feeding child? If yes which ones?

_____

28. During labor was your child delivered vaginally, C-Section, Forceps and or suction devices? Was there a concern for trauma?

_____

Parent's Medical History:

29. Do the child's parents suffer from any of the following medical conditions?

___ Low Thyroid ___ Thyroid Cancer ___ Parathyroid Problems ___ Night Blindness
___ Autoimmune Disorders ___ Lupus ___ Connective Tissue ___ Rheumatoid Arthritis ___ Cancer
___ High Blood Pressure ___ Other: _____

30. Did the mother have any dental work done while pregnant? If yes, please explain:

_____

31. Is there a family history of Developmental Disorders (i.e., autism, PDD, etc.)? Explain:

_____

32. Is there a family history of Neurological disorders, i.e. multiple sclerosis, etc.? Explain:

_____

33. Is there a history of Asthma, Allergies, Autoimmune Disorders (Lupus, Rheumatoid Arthritis…)? Explain:

_____

34. Is there a family history of blood disorders (i.e., clots, Stokes, Hemophilia, or Platelet Disorders)? Explain:

_____

35. Is there a family history of Psychiatric disorders, i.e. depression, schizophrenia, etc.? Explain:

_____

36. Is there a history of genetic disorders? Explain:

_____

37. Is there a history of seizures or vaccine reactions? Explain:

_____

38. Is there a family history of celiac disease or gluten intolerance? Explain:

_____

Vaccination History:

39. Has your child received all the recommended vaccinations for his age? _____

40. Has your child received any of the following vaccination:
___ DTP ___ DTap ___ MMR ___ Hib ___ Hep B___ OVP ___ IVP ___ Pneumonia ___ Chicken Pox
___ Flu

Other, list:

_____

41. Do you feel your child's behavior changed after receiving a particular vaccine? Which one and explain behavior. _____

42. How long after the above vaccine did your child become sympathetic? Explain:

_____

43. Did your child receive any vaccinations when they were sick? If yes explain

_____

44. Did your child suffer from any vaccine reactions listed below:
___ Fever degrees ___ Inconsolable Screams ___ Excessive lethargy ___ Rashes ___ Hives ___ Vomiting ___ Seizures Other:

Medication Usage:

45. Is your child allergic to any medication? List:

_____

46. Has your child taken any steroid medication that is inhaled, oral use or injections? Explain:

_____

47. Has your child taken any medication for yeast or Candida infections?

_____

48. Please list all medication and supplements your child is currently taking.

_____

_____

49. Any other information you would like Dr. West to know?

_____

_____

_____

_____

_____

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OFFICE POLICY

The following information explains our policies and procedures. Please read it carefully and sign at the bottom. If you have questions, please ask any member of the staff and they will be happy to answer your questions.

SCHEDULE OF FEES

New Patient Detailed Consultation (Cancer - Autism):	Approx. 60 minutes - $850
New Patient Comprehensive Consultation:	Approx. 45 minutes - $700
New Patient Consultation:	Approx. 30 minutes - $550
New Patient Brief Consultation:	Approx. 15 minutes - $400
Craniosacral Osteopathy:	Approx. 45 minutes - $275
Follow-Up Appointment Regular:	Approx. 30 minutes - $275
Follow-Up Appointment Short:	Approx. 15 minutes - $175
Blood Draw - Processing Fee:	$75
Additional Special Needs Blood Draw – Processing Fee:	$60
Preauthorization for Medications - New Request:	$25

* There will be a $25 charge for simple forms or letters requested that Dr. West fills out for her patients. Legal documents are $100.

We accept all credit cards, debit cards, check or cash. Pricing for treatments, medications, supplements or consultations are subject to change at any time.

Dr. West also provides nutritional supplements, intravenous therapies and certain lab tests which may not be covered or reimbursed by insurance companies.

**We do not refund opened purchased supplements or products. If the supplement or product has been unopened, we will grant a credit to the patient's account - we charge a 20% restocking fee.*

PPO OUT-OF-NETWORK INSURANCE

If you have a PPO Insurance, you are out-of-network with our office. We can still provide you a HCFA form (Health Insurance Claim Form), which you can submit to your insurance. *Please make sure to ask for this form.*

We cannot negotiate with a patient's carrier on their behalf. If you are unsure of your insurance benefits, or have questions regarding reimbursement, please contact your insurance company directly, as the information can often only be communicated to you, the patient.

Please note that your insurance policy is an agreement between you and your carrier. We are not part of a contract with your insurance company and therefore cannot guarantee any level of insurance reimbursement.
If a patient's insurance carrier refuses payment, for any reason, the patient remains responsible for the charges. Dr. Rachel West Inc. withdraws itself from involvement in out-of-network insurance disputes, but will provide the patient, or their insurance company, with any information that we are capable and able to release.

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LABS/ SPECIALTY LABS

Dr. West's office works with various labs (e.g., Great Plains, Quest Diagnostics, Lab Corp, Pacific Medical Laboratory, Health Diagnostics, Doctors Data, Genova). This list is not exhaustive and evolves over time. The majority of the aforementioned labs can submit to the patient's insurance for any blood work/tests done through our office. **However, patients can often benefit from our office's special cash price, which might end up costing you less than the price you would pay if using your insurance.**

Additionally, when the patient's insurance does not cover the full amount billed, the patient is responsible for any unpaid amounts to the labs (i.e., co-payments, co-insurance and/or deductibles). These matters need to be taken up directly with the specific lab used for the patient's testing. Dr. West cannot be held responsible for any open balances related to payments that the patient's insurance refused to make for these labs.

TELEPHONE AND PHYSICIAN CONTACT PROTOCOL

If a patient has a reaction to a medication, the best course of action is to stop taking the medication and schedule a follow-up visit.

In most cases, Dr. West is not able to communicate with patients outside of scheduled office visits – as she needs to be able to focus on her patients of the day. However, **patients are always welcome to leave a message with Dr. West's assistant team – email (assistant@longevity.la) or text messages: (310) 560-0241 or (310) 560-0547.**

Questions that require a medical decision cannot be answered via e-mail; they require an office visit or phone consultation. Consultations may take place over the phone – especially follow-ups, but generally not initial consultations (except when justified). Phone consultations will be billed like regular office visits.

RESCHEDULING & CANCELLATION

To better serve all patients, our office abides by the following Cancellation Policy:

APPOINTMENT TYPE	TIME FRAME	Charge
New Patient Appointment	2 business days	½ scheduled visit price
Follow-up Appointment	1 business day	½ scheduled visit price
High Dose Ozone	1 business day	$85
IV Appointments	Same day	$35

By signing below, you – the patient or guardian – have read, acknowledge that you have read and that you understand and agree with all statements written above. Furthermore, you, the patient or guardian, have been informed of and understand your insurance coverage and benefits while being under Dr. Rachel West's care. You also understand that any visits, treatment or services done through Dr. Rachel West Inc. that may not be covered by your insurance are your responsibility to pay.

_____
Patient's Printed Name

_____ _____
Patient's or Legal Guardian's Signature Date

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Cancellation Policy

Please let us know as early as possible if you need to change your doctor's appointment. A notice of at least 24 business hours is appreciated if you are unable to keep your scheduled follow-up appointment and 48 hours for New Patient appointments.

Late cancellations or no-shows will be subject to a late cancellation fee of up to 50% of the scheduled office visit charge as described on the form "Office Policy."

Other Procedure Fees

Due to the rapidly increasing and time-consuming nature of managing requests from insurance companies, disability forms, e-mails, etc, we are charging a nominal fee for these services.

1. Disability Claims: $4 per page

2. Legal Letters: $100 plus additional charges depending on the amount of time required to review your chart

3. Letter of Medical Necessity: $25

4. Jury Duty Forms: $25

5. Copying of Medical Records: $30 for patient

6. Copying of Medical Records: $40 to prep for outside duplication

7. **Prior Authorization:** Insurance companies are requiring Prior Authorization on more and more medications. This can be a very lengthy process, and there is no guarantee that it is approved. If you want our Medical Assistants to work on Prior Authorization for you, we charge $25.

8. **E-mails**: No charge for e-mails that are one question and/or short response
   $25 for e-mails that have more than one question

Due to the high number of e-mails that we receive daily, please be aware that it may take a few days to receive a response. If the matter requires an immediate response, please call the office.

I acknowledge and accept the above Policies.

Patient Name _____ Date_____

Patient Signature _____

PHYSICIAN-PATIENT 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 California 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 the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this 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.

By: _____
Physician's or Duly Authorized Representative Signature (Date)

By _____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Patient's Representative's Signature (if applicable)(Date)

_____
Print Name and Relationship to Patient

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

WE CANNOT SHARE ANY OF YOUR MEDICAL INFORMATION WITH A SPOUSE/PARENT/CHILD/FRIEND WITHOUT YOUR AUTHORIZATION

PLEASE FILL OUT THIS FORM IF YOU WANT TO GIVE US THE ABILITY TO COMMUNICATE ABOUT YOUR CARE WITH A SPOUSE/PARENT/ CARE COORDINATOR/FRIEND.

RECIPIENT:

I voluntarily consent to authorize Dr. Rachel West (my health care provider) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

I authorize my health care information to be released to the following recipient(s):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

INFORMATION TO BE DISCLOSED:

I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, physical condition, and any treatment received by me.

☐ Only the following records or types of health information:

_____

Terms:

This Authorization will remain in effect:

☐ From the date of this Authorization until _____

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Guardian Date Signature of Witness

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Informed Consent
for Intravenous and Intramuscular Nutritional Therapies

I give Dr. Rachel West, Inc. as well as the Staff at her Office, Longevity LA, permission to perform single or recurring intravenous and intramuscular Nutritional Therapy ("NT"). I am executing this consent to confirm my understanding of the risks, benefits, and alternatives to treatment with NT.

1. Benefits of intravenous and intramuscular Nutritional Therapy

Intravenous and intramuscular Nutritional Therapy (NT) is used for a variety of conditions which include but are not limited to dehydration, vitamin, mineral and amino acid deficiencies, malabsorption, acute or chronic viral conditions, immune deficiencies, persistent fatigue, brain fog and exposure to chemicals and heavy metals. The various NT protocols are provided to me according to the guidelines established by the American College of Advancement in Medicine (ACAM), the American Academy of Environmental Medicine (AAEM), and other professional organizations.

NT consists of the application of vitamins (e.g. B1, B2, B5, B6, B12, B complex, C, D), minerals (e.g. magnesium, calcium, sodium, zinc, selenium, trace minerals), amino acids (e.g. taurine, glutathione), anti-oxidants (e.g. Alpha Lipoic Acid) and nutrients (e.g. phosphatidylcholine).

IV Therapy is not affected by stomach or intestinal disease; the total amount of infusion is available to the tissues; Nutrients are forced into cells by means of a high concentration gradient, higher doses of nutrients can be given than possible by mouth without intestinal irritation. NT should not be taken on an empty stomach.

I understand that Dr. West makes no representations, claims or guarantees that my medical problems or conditions will be helped by undergoing NT.

2. Risks of intravenous therapy include, but are not limited to:

Discomfort, bruising or pain at the injection site; skin rash; nausea; dizziness; fatigue; feeling lightheaded, flushing; headache; infection; lowering of blood sugar levels (hypoglycemia); lowering of blood pressure; inflammation of the veins (thrombophlebitis); inflammation of the vein used for injection and/or phlebitis allergies including life threatening anaphylactic reactions, severe allergic reaction, anaphylaxis, cardiac arrest and/or death.
A common objection against NT is that a patient might delay or forego undergoing a generally accepted medical treatment.
In case of cancer and other life-threatening disease, I understand that NT is best used as an adjunct to the therapy recommender by my oncologist or specialist.

Your signature below means that:
a. You understand the information provided on this form and agree to the foregoing.
b. The procedure(s) set forth above has been adequately explained to you by your physician.
c. You have received all the information and explanation you desire concerning the procedure.
d. You authorize and consent to the performance of the procedure(s).

Printed Name: _____

Signature: _____ Date: _____

RACHEL WEST, D.O.
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Consent and Authorization for Intravenous Therapy

Dr. Rachel West, Inc provides this facility and its personnel to allow the performance of intravenous therapy. You have the right to be informed of the procedure, any feasible alternative options, as well as risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive this information and to give your informed consent.

The procedure involves inserting a needle into your vein or muscle and injecting a formula. You have the right to ask the exact contents of the formula given to you. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.

Risks of intravenous therapy include, but are not limited to:

I. Discomfort, bruising or pain at the site of injection
II. Nausea, feeling lightheaded, flushing
III. Inflammation of the vein used for injection and/or phlebitis
IV. Severe allergic reaction, anaphylaxis, cardiac arrest and/or death

Benefits of intravenous therapy include:

I. IV Therapy is not affected by stomach or intestinal disease
II. The entirety of the infusion is available to tissues
III. Nutrients are forced into cells by means of a high concentration gradient
IV. Higher doses of nutrients can be given than possible by mouth without intestinal irritation

You have the right to consent to refuse the proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedure(s) described above as well as any different or further intravenous therapy procedures which, in the opinion of your physician, may be indicated. The procedure will be performed by or under the direction of Rachel West, D.O., along with qualified medical assistants and nurses.

IV costs consist of two parts:

1) Medications NOT covered by insurance
2) Covered medications and procedures

A small portion of the IV costs may be reimbursed by your insurance.

Your signature below means that:

a. You understand the information provided on this form and agree to the foregoing.
b. The procedure(s) set forth above has been adequately explained to you by your physician.
c. You have received all the information and explanation you need concerning the procedure.
d. You authorize and consent to the performance of the procedure(s).

Printed Name:_____

Signature:_____ **Date:** _____

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