RACHEL WEST, D.O.
CONTEMPORARY MEDICINE
12300 Wilshire Boulevard, Suite 420 - Los Angeles, CA 90025
Tel: 310.450.8959 - Fax: 310.450.8342 - Web: 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 NUMBER: _____
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): _____

Rachel West, D.O. –
Health History Adult Questionnaire

Please answer all section that pertain to your health. All of your answers will be kept confidential.

Name of patient: _____ DOB: _____
What is your occupation? _____

Main reason(s) for visit: _____
When did the problem(s) begin? _____

To what extent does your problem interfere with your daily activities (work, sleep, school, personal life, etc.)? Is this a sudden offset or is it gradual? _____

What type of treatments have you tried for your problem?
__Acupuncture __ Craniosacral __Vitamins __Other_____
Which of these therapies have been most helpful? _____

List other areas of your health that you would like help with and when they began:
_____

Medical History:

__ Arthritis __ Asthma __ Cancer __ Diabetes __ Hepatitis __ High/Low Blood Pressure
__ Heart Disease __ Leukemia __ Multiple Sclerosis __ Rheumatic Fever __ Stroke
__ Seizures __ Thyroid Disease __ Lung Disease __ Kidney Disease __ Venereal Diseases
__Other: _____

Family Medical History: _____

Past Surgical Procedures and Dates: _____
_____

Significant Past Traumas:
__ Car Accident __ Whiplash __ Falls __ Head injuries __ Birth Trauma __ Loss of Consciousness
__ Broken Bones __ Hospitalization __Other: _____

Do you have any drug allergies? List medications and reaction to these medications:
_____
_____

List all medications you are currently taking, including supplements and birth control:
_____
_____

DENTAL HISTORY: Have you ever had orthodontic work done, had braces causing complications, mercury fillings gingivitis or repetitive oral problems?
_____

Please answer the questions that are most applicable to you
(1. Mild 2. Moderate 3. Severe)

AUTONOMIC & ACID BASE SYMPATHETIC:

___Dry Mouth, eyes, nose
___Easily startled, unable to relax
___Heartburn
___Staring blinks little
___ Cold sweats
___Feverish
___Cannot fall asleep at night
___Sweaty, palms, soles, forehead, underarms
___Strong light irritation
___Nervous stomach

PARASYMPATHETIC:

___Slow starter
___Eyes blinking often
___Gag reflex
___Difficult swallowing
___Eyes or nose watery
___Perspires easily
___Constipation & diarrhea alternation ___Slow pulse (irregular)
___Joints stiff after arising
___Always seems hungry

SUGAR HANDLING

___Eats when nervous
___Gets "shaky" if hungry
___Abnormal cravings for snacks
___Awaken after hours of sleep
___Eating relieves fatigue
___Overeating sweets upset stomach
___Moods of Depression
___Excessive appetite
___Craves candy/coffee in afternoon
___Afternoon headaches
___Hungry/irritable between meals
___Lightheaded if meals missed

CARDIOVASCULAR:

___Chest Pains
___ Low-High blood pressure
___Blue black spots in body
___Feet swelling at night
___Irregular heartbeat
___Low Iron
___Often drowsy
___Numbness in arms or legs
___Sighs frequently
___Varicose veins
___Stroke or mini-Stroke
___Low B-12
___Cold fevers
___Bruises easily
___Muscle cramps, Charley Horse
___Afternoon yawner
___Nose bleeds
___History of Anemia
___Dizzy when standing up

GASTROINTESTINAL & DIGESTION LIVER & BILARY:

___Gallstones
___Itching skin
___Hair falling out
___Stools light colored
___Burning / itching
___Burning feet
___Lactose intolerant
___Queasy feelings
___Fatty food intolerance
___Dry skin
___Bad breath
___Insecure

DIGESTION:

___Black or bloody stools
___Foul smelling stools
___Large amounts of gas
___Indigestion after eating
___Bloated after eating
___Cramps in lower abdomen
___Burping or belching after meal
___Hepatitis or ulcers
___Irritable bowels
___Coated tongue
___Heartburn or Indigestion
___Nausea or Vomiting

SKIN, NAILS & HAIR:

___Itching
___Dandruff
___Acne or pimple
___Sunburned easily
___Hair falls out
___Flushing or blotches
___Hives
___Premature grey hair
___Rough skin on arms or legs
___Psoriasis
___Hang nails
___Poor wound healing
___Rashes
___Eczema
___Corners of mouth cracked
___Brittle fingernails
___Recent moles
___Greasy skin

ENDROCRINE GLANDS

HYPERTHYROID:

___Cannot gain weight
___Irritable & restless
___Intolerance to heat
___Thin moist skin
___Pulse fast at rest
___Highly emotional

HYPOTHYROID:

___Increase of weight
___Constipation
___Fatigued easily
___Intolerance to cold
___Mental sluggish
___Appetite decreased
___Slow pulse
___Dry scaly Skin
___Coarse hair falls out

HYPER-PITUITARY:

___Low Blood pressure
___Increased sex life
___Failing memory

HYPO-PITUITARY:

___Always thirsty
___Bloating of abdomen
___Decreased sex life
___Weight gain around waist or hips

HYPER-ADRENAL:

___Facial or body hair (women)
___Hot flashes
___Headaches

HYPO-ADRENAL:

___Weakness or dizziness
___Arthritis tendencies
___Low blood pressure
___Respiratory disorders
___Craves salt
___Weakness after flu or cold

FEMALE & MALE SPECIFICS:

FEMALE:

___Menstrual cramps
___Missed menstruation
___Painful breasts
___Frequent yeast infections
___Irregular periods
___Premenstrual depression
___Hot flashes
___Excessive or prolonged periods
___Anxiety before period
___Ovaries removed
___Cysts

MALE:

___Prostate trouble
___Diminished sex drive
___Feeling impotent
___Frequent urination at night
___Tired easily
___Migrating aches & pains
___Lack of energy
___Depression

MUSCULOSKELETAL & CALCIUM METABOLISM:

___Neck pain
___Foot or ankle pain
___Shoulder pain
___Joints injure easily
___Muscle spasm
___Kidney Stones
___Chiropractic type adjustments
___Back pain
___Hip pain
___Degenerative joint disease
___Muscle pain
___Numbness
___Carpal tunnel syndrome
___Osteoporosis
___Knee pain
___Hand or wrist pain
___Joint stiffness
___Muscle weakness
___Tremors or shakiness
___Balance difficulties
___Recent dental cavities

HEADACHES:

___Migraines
___Stiff neck
___Teeth grinding
___Dull pressure type
___Backache
___Orthopedic work recently
___Pain wakes you from sleep
___Jaws pops, locks, grinds
___One side headaches

When did the headaches first begin? How long do they usually last? What helps to relieve them? What triggers them? _____

NEUROPSYCHOLOGICAL:

___History of seizures
___Poor memory
___Learning disorders
___Withdrawn socially
___Attention deficit disorder (ADD)
___Poor concentration
___Very restless
___Restless mind
___Depressed unmotivated
___Poor performance
___Difficult sleeping
___Suicidal thoughts

MISCELLANEOUS:

___Catches colds easily
___Cold or canker sores
___Frequent bronchitis
___Bleeding gums
___Shingles
___Swollen lymph nodes
___Herpes virus
___Loss of smell
___Toenail fungus
___Yeast or bladder infection
___Plastic surgery
___Loss of taste

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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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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 Consultation:	Approx. 45 minutes - $900
New Patient Consultation (Cancer - Autism):	Approx. 60 minutes - $1100
Craniosacral Osteopathy:	Approx. 45 minutes - $900
Follow-Up Appointment Regular:	Approx. 30 minutes - $400
Blood Draw - Processing Fee:	- $75
Preauthorization for Medications - New Request:	- $25

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.

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

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.
Patients are welcome to send a message to Dr. West's team via email (assistant@longevity.la and assistant@drrachelwest.com) or text messages: (310) 560-8982 or (310) 913-9961.

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. Phone consultations are billed like regular office visits.

RESCHEDULING & CANCELLATION

To better serve all patients, our office abides by the following Cancellation Policy:
- **New Patient Appointment**: We charge the scheduled visit price if the visit is cancelled or rescheduled within 48 hours of the appointment.
- **Follow-up Appointment**: We charge the scheduled visit price if the visit is cancelled or rescheduled within 24 hours of the appointment.

- IV Appointments	Same day	$35
- High Dose Ozone	1 business day	$85

By signing below, you (patient or guardian), acknowledge that you have read and agree with all statements written above. You also understand that any visits, treatment or services done through Dr. Rachel West Inc. which are not covered by your insurance, are your responsibility to pay.

_____
Patient's Printed Name

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

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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Informed Consent
for Intravenous and Intramuscular Nutritional Therapies

I give Dr. Rachel West, Inc. as well as the Staff at her Office, Longevity Medical Center, 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 (IINT) 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 IINT 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. IINT 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 should typically not be done 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 IV Therapy treatments.

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 IV nutritional therapy 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 IV nutritional therapy is best used as an adjunct to the therapy recommended 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: _____

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Cancellation Policy

Please let us now as early as possible if you need to change an appointment. Late cancellations or no-shows will be subject to a cancellation fee of the scheduled office visit charge.

To better serve all patients, our office abides by the following cancellation policy:
- **New Patient Appointment**: We charge the scheduled visit price if the visit is canceled within 48 hours of the scheduled appointment.
- **Follow-up Appointment**: We charge the scheduled visit price if the visit is canceled within 24 hours of the scheduled appointment.

Please note that we are open 8:30 am – 5:30 pm on Fridays, so cancellations for a Monday appointment need to be done before we close on Friday.

Other Procedure Fees

Due to the time-consuming nature of managing requests from insurance companies, disability forms, etc… Our office charges a nominal fee for the following services.

1. **Disability Claims**: $4 per page
2. **Disability Letter**: $40 depending on amount of time required to review your chart
3. **Letter of Medical Necessity**: $25
4. **Jury Duty Forms**: $10
5. **Copies of Medical Records**: $30 for patient - $40 to prep for outside duplication
6. **Prior Authorization**: This can be a very lengthy process, and there is no guarantee that it is approved. We charge $25/half hour of time spent.
7. **E-mails**: No charge for e-mails that are a short question and/or short response - $25 for e-mails that involve complex solutions and/or medical decision making.

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.

I acknowledge and accept the above Policies.

Patient Name: _____ Date: _____

Signature: _____

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