



2211 CORINTH AVENUE, SUITE 204 • LOS ANGELES, CA 90064  
TEL: (310) 450-8959 • FAX (310) 966-9196 - 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  Cranial Sacral  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 mostly apply 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 heart beat
- 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
- Bloating 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

## ENDOCRINE 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



# Pediatric Health History Information

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

1. What brought you and your child in today?

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

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## **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:

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## **Digestive Health:**

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

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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.

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14. Main reason for antibiotic use:

Ear infection  Bronchitis  Pneumonia  Sinus Infection  Intestinal Infection

Other, please explain: \_\_\_\_\_

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

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**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:

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

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

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

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**Mother's Pregnancy and Labor:**

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

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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?

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

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

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**Parent's Medical History:**

29. Do the child 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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# 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

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

### SCHEDULE OF FEES

New patient Detailed Consultation (Cancer - Autism):	Approx. 60 minutes-\$750
New Patient Comprehensive Consultation:	Approx. 45 minutes-\$600
New Patient Consultation:	Approx. 30 minutes-\$450
New Patient Brief Consultation:	Approx. 15 minutes-\$300
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
Special Needs Blood Draw – Processing Fee:	\$100
Preauthorizations 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 patients 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, such as 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](mailto:assistant@longevity.la)) or text messages: (310) 560-0241.**

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:

New Patient Appointment	2 Business day	½ scheduled visit price
Follow up appointment	1 Business day	½ scheduled visit price
IV appointments	Same day	\$35
High Dose Ozone	1 Business day	\$85

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

## 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 (Date)  
Authorized Representative Signature

By: \_\_\_\_\_  
Patient's Signature (Date)

\_\_\_\_\_  
Print Patient's Name

By \_\_\_\_\_  
Print or Stamp Name of Physician,  
Medical Group or Association Name

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

By: \_\_\_\_\_  
Signature of Translator (if applicable) (Date)

\_\_\_\_\_  
Print Name and Relationship to Patient

\_\_\_\_\_  
Print Name of Translator



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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 (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:

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

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# RACHEL WEST D.O.

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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 appointment. Please note that we are open from 9am-3pm on Fridays, so cancellations for a Monday appointment need to be done before we close on Friday.

Late cancellations or no-shows will be subject to a late cancellation fee of 50% of the scheduled office visit charge.

## 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. Disability Letter:** \$40 depending on the length of the letter and amount of time required to review your chart
- 3. Letter of Medical Necessity:** \$25
- 4. Jury Duty Forms:** \$10
- 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/half hour of time spent.
- 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.

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I acknowledge and accept the above Policies.

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Signature \_\_\_\_\_



RACHEL WEST D.O.  
INTEGRATIVE FAMILY MEDICINE

CREDIT CARD ON FILE POLICY

At our medical facility we require keeping your credit card on file as a convenient method of payment for which you are liable.

Without this authorization, a billing fee of \$10 may be added to your account for any balances that we must attempt to collect through mailing monthly statement.

Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed at the end of the day only if payment for services rendered to you have not been received by this office.

I authorize my physician, Dr. West, to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient/Cardholder Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I the undersigned, authorize and request my physician/staff, to charge my credit card, indicated above, for balances due for services.

This authorization relates to all payments for services rendered to me.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to my physician in writing and the account must be in good standing.