Patient Registration
Tina B. West, M.D.

Date: _____ SSN: _____

Patient Name: _____ Date of Birth: _____Age_____

Preferred Mailing Address: _____

City: _____State: _____Zip Code: _____

* Check Preferred Contact

□ _____□Cell Phone: _____□Work Phone: _____

Employer: _____Occupation: _____

Employer's Address_____

Email: _____

I authorize Tina B. West, M.D., P.C. to send me newsletters, practice updates and other correspondence via email. □Yes □No

Referred by: _____

Purpose of Today's Visit? _____

_____

Current Medications (please include herbal supplements): _____

_____

Allergies (medications/food/etc.): _____

NOTE: PLEASE CAREFULLY READ OUR PAYMENT AND APPOINTMENT POLICY

A. Payment is due at the time services are rendered. You will be provided a copy of your receipt for filing an insurance claim if applicable. (Please note we do not participate with any insurance companies.)

B. All patients covered by **MEDICARE** should note that their fees will not be reimbursable by Medicare and that the patient is solely responsible for all consultation and treatment fees.

C. **NEW PATIENTS**: There is a $100.00 non-refundable deposit at the time of scheduling of your first appointment. This amount will be credited toward your initial consult fee with Dr. West. Please call us at **(301) 986-WEST (9378) 48-hours prior to your scheduled appointment** to notify us of any changes or cancellation. **To cancel a Monday appointment, please call our office by 4:00pm on Friday**. If prior notification is not given, you will be charged $100.00 for the missed appointment. Before scheduling another appointment, we will require another non-refundable deposit of $100.00

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D. **Cancellation & No-Show Policy:** Regretfully, we have been forced to institute this policy due to a large volume of last minute cancellations, scheduling changes and "no-shows." We make every effort to provide prompt care to all of our patients.
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel/reschedule an appointment, you may be preventing another patient from being seen. Conversely, the situation may arise where another patient fails to cancel, and we are unable to book you for a visit, due to a seemingly "full" schedule. If a patient arrives 15 min past their scheduled appointment time, we will have to reschedule the appointment. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. If you are unable to keep a scheduled appointment, please let us know 48 hours in advance.

   A NO SHOW is when a patient fails to keep a scheduled appointment. A NO SHOW will generate a $100.00 fee for any appointment at the West institute.

E. There will be a $50.00 fee for any returned check.

F. Returns or exchange on products will be accepted within 30 days of purchase. Products will not be accepted for return or exchange **after** 30 days.

Your signature below confirms that you have provided correct information and that you understand and agree to the policies listed above.

Patient Signature: _____ **Date: _____**

Print Name: _____

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THE WEST INSTITUTE

Customized Treatment Plan

Dr. West and her highly trained staff take great pride in providing you with the best services and effective treatment options available to meet your specific needs. In order to customize your treatment plan, please indicate your specific areas of concern.

Patient Name: _____ Date: _____

Please circle all conditions that are a concern for you:

Acne (face, chest, back)
Age Spots
Black Heads
Large Pores
Actinic Keratosis (Pre-Cancers)
Major Lines around Nose and Mouth
Brown Spots on Face
Cellulite (arms, abdomen, thighs, buttocks)
Pockets of Fat
Stretch Marks
Dark Hair on Face and Body
Hyperpigmentation
Dry Skin
Hyperhidrosis (excessive sweating)
Photoaging
Tattoos
Wrinkles
Melasma
Premature Fine Lines
Aging Hands
Leg Veins
Loose Neck Skin
Forehead Lines
Skin Tags
Moles

Uneven Skin Tone
Tired Looking Skin
Sunken Cheeks
Rosacea
Sagging Skin (Loss of Elasticity)
Telangiectasia/(Facial Blood Vessels
Broken Capillaries
Vascular Birthmark
Rough Texture of Skin
Spider Veins (legs)
Freckles
Hair Loss
Under Eye Hollows
Chin Dimpling
Dark Circles Under Eyes
Uneven Pigmentation
Undefined Jawline
Hollow Temples
Bands on Neck
Undefined Lip Border
Upper Lip (Puckering)
Crow's Feet
Bags Under Eyes
Sagging or Flat Earlobes

Ranking of Concerns: 1._____

2._____

3._____

4._____

5._____

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am a patient of the West Institute. I hereby acknowledge receipt of
The West Institute's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].
I hereby acknowledge receipt of The West Institute's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____