Patient Registration
The West Institute

Date: _____ SSN: _____

Patient Name: _____ Date of Birth: _____Age_____

Preferred Mailing Address: _____

City: _____State: _____Zip Code: _____

* Check Preferred Contact

Home_____ ☐Cell Phone: _____ ☐Work Phone: _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address_____

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. You understand that 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. If you are covered by **MEDICARE** you understand that their fees will not be reimbursable by Medicare and that you are solely responsible for all consultation and treatment fees.

C. NEW PATIENTS: You understand there is a $250.00 initial consultation 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.

D. Cancellation & No-Show Policy: We understand that there are times when you must miss an appointment due to emergencies or unforeseen obligations for work or family. However, when you do not call to cancel/reschedule an appointment, you may be preventing another patient from being

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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 minutes 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 business hours in advance.**

If an appointment is cancelled within the 48 hours window, you will be charged a $100 fee.
If you have a Monday appointment, please contact the office no later than the Thursday prior.

A NO SHOW: if you do not show for your appointment, you will be charged $100.

E. You understand that we will not submit insurance reimbursement paperwork on your behalf; we will however provide you with our standard form which you may submit yourself.

F. You agree that we may charge your credit card $50 if your check is uncollectable.

G. 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 above policies.

Patient Signature: _____ **Date:** _____

Print Name: _____