



Patient Registration
The West Institute

Date: _____ Patient Name: _____ Date of Birth: _____ Age _____

Preferred Mailing Address: _____

City: _____ State: _____ Zip Code: _____

* Check Preferred Contact

↑ Home _____ ☐ Cell Phone: _____ ☐ Work Phone: _____

Email: _____

Employer: _____ Occupation: _____

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

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

Patient Signature: _____

Date: _____