PATIENT INFORMATION

Date______________ Name ____

DOB___/___/_____ Age_____ Gender_____ Height___________ Weight__________

SSN____

Address____

Street City State/Prov. Zip/Postal Code

Telephone: Home/Cell (____)_____-________ Work (____)_____-________

Email______________________________ Employer_____________________________

If you do not wish to recieve promotional emails initial here _____

Occupation_____________________________________

Whom referred you to the office?____

**We have a special referral program– please be specific in your referral.*

Emergency Contact ____

Name Telephone

INSURANCE

Some people ask why we don't take insurance as payment. Fair Question, here is the answer straight from the government: Medicare Guidelines, Section 2251.3: "a treatment plan that seeks to prevent disease, Promote health, and Prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition is deemed **NOT MEDICALLY NECESSARY"...** This means that third party payers, (Blue Cross, Blue Shield, Aetna, United) now have government permission to deny health insurance claims.

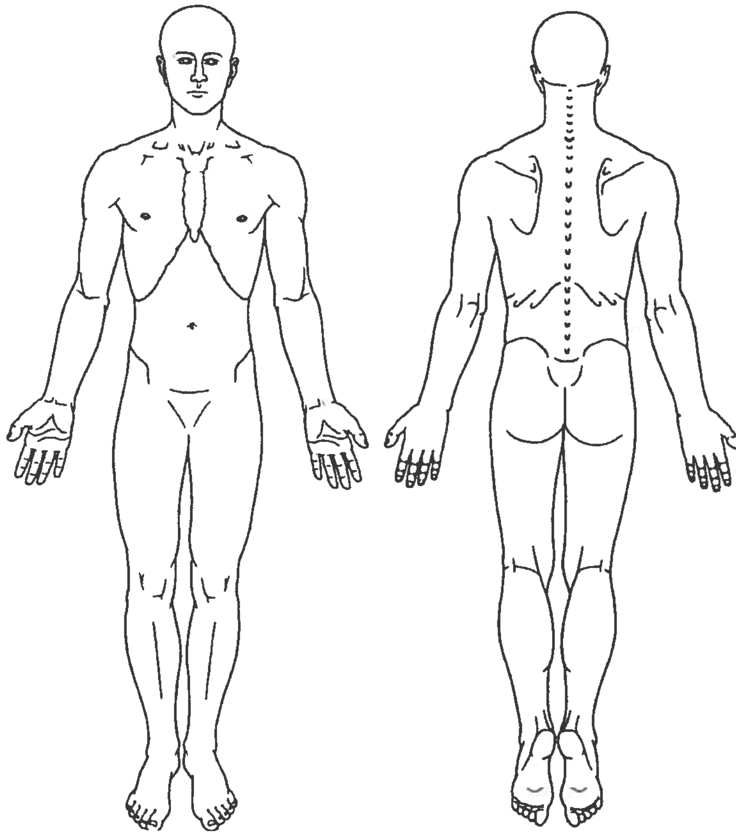
The Cutting Edge, Outside the box approaches we take in addressing issues related to your condition are not covered by Medicare and Medicaid, and most insurance plans we've worked with in the past have also turned down claims for some of the procedures we do in this clinic. Therefore, we are no longer contracted with them. Insurance companies can be very restrictive in the types of options you might have available. Moving outside of the metaphorical box of approaches that insurance limits you to allow for the cause(s) of your condition to be determined, rather than simply offer options to continue treating the symptoms. When you begin to operate outside of insurance limited health care, you are able to determine how the other "outside-the-box" categories are affecting your health. Bridging the gaps between symptoms from various systems in the body, determining auto-immune triggers, and discovering other deficiencies that are contributing to your condition are also made possible when going beyond the medical standard of care.

PURPOSE OF VISIT AND INJURY INFORMATION

What Services are you expecting? *(Circle all that apply)*

IV	HCT	Asyra
Prolozone	Hormone Consult	Frankenhauser
Consultation	Weight	Crown Of Thorns
Neural	Microscope	Other:________

Please Mark where it hurts:



When did the problem start? ________________________________

What makes it feel better? ________________________________

____

What makes it feel worse? ________________________________

____

Does it hurt more in the: Morning Evening

Where does the pain go? ________________________________

____

Do you attribute your condition to a particular accident or illness (Please indicate a date) ________________

Please list any other relevant health problems ________________

Major Illnesses________________

Accidents or Major Trauma (Please indicate location of any significant scars) ________________

Current Prescription Medications (Names and Doses) ________________

Allergies/sensitivities: Foods, Environmental, etc. ________________

Have you been exposed to occupational chemicals? (Asbestos, Fertilizer, toxic fumes, etc.) ________________

How active are you? Do you exercise consistently? ________________

Please list any vitamins, minerals, herbal formulas, or other supplements you are taking. (Name, Manufacturer, and Dose) ________________

PATIENT CONDITIONS OF TREATMENT AND INFORMED CONSENT TO TREAT

Clinic Treatment(s)

This document is a binding agreement (the "Agreement") between The West Clinic, Dr Jason West, and/or (We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

1. **Consent for Treatment.** You hereby consent to and authorize Us to provide You with health care treatment, including without limitation medical, diagnostic, nutritional treatment, Intravenous Micronutrient Therapy, Prolotherapy and Prolozone (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You understand that the practice of health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment.

2. **Experimental Nature of Treatment.** You acknowledge and agree that the evaluation, diagnosis and treatments may consist in whole or part of experimental procedures and methods, including without limit Intravenous Micronutrient Therapy, Prolotherapy and Mesotherapy, on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has issued any guidelines or statements as to the safety or efficacy thereof. You acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. We have informed you that the Treatments MAY alter, address or decrease you pain, symptoms or complaints, but also may have no effect.

3. **Risks, Side Effects, Complication.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation infection; swelling; increased pain; bleeding; scarring; scar or wound enlargement; keloid formation; asymmetry; temporary or permanent alteration in sensation; allergic reaction; discoloration; the need for additional surgery; soreness, itching, infection, injury to nerves, internally and externally leaking fluid and scaring at injection sites (all of which except the leaking fluid may be permanent), a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments; spinal cord injuries, Pneumothorax (air on the outside of the lung), paralysis, dizziness, numbness, no benefit from Treatments; or other serious or debilitating injuries or death.

4. **Description of Treatments.** You acknowledge that the Treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, homeopathic medicines, and FDA approved prescriptive medicines, local anesthetic (Procaine or Lidocaine), concentrated sugar water or dextrose, and, on occasion ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to you when we actually administer the Treatments.

5. **Health Care Staff.** You are aware that among those who attend you on our behalf are medical, nursing, and other health care personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You further consent to the presence of service representatives and/or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during operation, procedure and Treatments.

6. **Information You Provide Us.** You have provided Us with a Complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided us with a complete list of all known allergies you may have, and all allergic or adverse reactions you have had in the past to any medicines, dietary supplements or medical treatments of any kind. You covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete and up-to-date to the best of Your knowledge.

7. **Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any question about this Agreement or the Treatments that you have, you are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments, but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed.

8. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action.

9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between you and us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by you. This Agreement shall be binding on you and your successors, heirs, legal representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the state of Idaho without regard to any choice of law principal. Any dispute between you and Us shall be adjudicated in state of federal court in Pocatello, Idaho, and You submit to the jurisdiction of any such court.

Patient signature: ______________________________

IMPORTANT MEDICAL LIABILIY INFORMATION AND AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION

We realize that the cost of malpractice insurance has risen to unacceptable levels. Dr. West and the staff are consulting with legal, insurance, risk-management, and other professionals to try and resolve this issue. Until it is resolved, Dr. West believes his patients should know that some of the procedures that are offered may not be insured for medical liability.

For the present, the only options are to close the clinic or to continue using some of these uninsured protocols and procedures while trying to resolve this problem. In deciding to continue, Drs. West will be instituting changes in his practice to more closely manage liability risk, but the intention is to continue to provide high quality Integrative Medicine.

Despite the best of care and intention, errors may occur, and medical errors may lead to harm. As part of our interim liability risk-management policy, all patients and/or their legal guardians are now asked to sign a copy of this form attesting to the fact that they are aware that Drs. West may not have medical liability malpractice insurance for some procedures and protocols.

In addition, we must now require that all patients formally agree to utilize alternative dispute resolution conditioning of a two-step process: First, mediation, and second, if necessary, binding arbitration. This process would be instead of litigation and cover any and all legal disputes involving any professional actions of Dr. West and/or the staff of West Clinic. This means that you are agreeing to any and all disputes relating to health/ medical care that is provided by Dr. West and/or the staff of West Clinic first to mediation, and if no resolution is achieved by mediation, then to bringing arbitration to be determined by a single arbitrator. The rules of the American Arbitration Association shall govern the mediation and binding arbitration and all proceedings shall be conducted pursuant to the rules of the American Arbitration Association.

These alternative dispute resolution methods are quicker and more cost effective in reaching an equitable solution for all parties involved. Because of the extreme overcrowding of the Court system and very high costs of litigation, these alternative dispute resolution methods are being increasingly employed as an alternative to the more costly and slower method of litigation by the judicial system.

The parties shall split the costs of mediating and disputes equally. Any attorney's fees incurred during mediation shall become a subject of the mediation and the parties will attempt to resolve attorney's fees during the mediation. The costs of binding arbitration shall be split between the parties equally and the arbitrator shall be empowered to award attorney's fees to the prevailing party.

Further, you agree that this agreement shall be governed by, construed, and enforced in accordance with the laws of the State of Idaho and subject to the jurisdiction of the First Judicial District Court of the State of Idaho in and/for Pocatello.

Dr. West understands that some may feel uncomfortable in signing this form. If that is the case, please do NOT sign until you discuss this with an attorney. Although Dr. West and the team will not be able to provide any professional services to patients who choose not to sign, we will provide any medical records we have in our profession to you free of charge so that you can select the healthcare practitioner of your choice for your continued care.

BY SIGNING THIS FORM(s), YOU ARE FORMALLY AGREEING TO ABIDE BY THE TERMS

DESCRIDED IN THIS DOCUMENT.

Patient

____

Signature

RESEARCH POLICY

Dear Patient,

It is our commitment to our patients to provide the best health history, questionnaires, diagnostic procedures, laboratory tests, and clinical exams (orthopedic, neurological, and clinical observation) that we know. This is completely consistent with the Idaho Chiropractic, Naturopathic and Acupuncture Laws. Specifically Idaho Code Section 54-703, 54-5104, and 54-4702.

- 54703 - The practice of chiropractic means: to investigate, examine, and diagnose for any human disease, ailment, injury, infirmity, deformity, or other condition;
- 54-4702. A naturopathic physician may use physical and laboratory examinations consistent with naturopathic medical education and training for diagnostic purposes.
- "Acupuncture" means that theory of health care developed from traditional and modern Oriental medical philosophies that employs diagnosis and treatment of conditions of the human body based upon stimulation of specific acupuncture points on meridians of the human body for the promotion, maintenance, and restoration of health and for the prevention of disease. Therapies within the scope of acupuncture include manual, mechanical, thermal, electrical and electromagnetic treatment of such specific indicated points. Adjunctive therapies included in, but not exclusive to, acupuncture include herbal and nutritional treatments, therapeutic exercise and other therapies based on traditional and modern Oriental medical theory.

The Government (State & Federal) creates policies and guidelines that are subject to change without notice that may carry sanctions and penalties unless the facility is involved in research. This facility participates in research. The purpose of this document is to inform you that it is possible that some of the assessments or procedures at this office are investigational and research oriented and that you are participating in research regarding your health.

Privacy Policy – The West Clinic will not release any information that may potentially identify you regarding any research project. By signing below, I am stating my understanding that this facility participates in research and that my privacy is inviolable.

____

Patient signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

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____________________________	____________
Employee signature	*Date*