

# The West Clinic

1188 Call Place  
Pocatello, Idaho 83201  
Ph. 208-232-3216 / Web: www.thewestclinic.net



## About You

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

Male  Female

What do you prefer to be called: \_\_\_\_\_

Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Address \_\_\_\_\_

City, State, Zip code: \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_

City, State, Zip code: \_\_\_\_\_

Mobile or cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Spouse Name (if applicable): \_\_\_\_\_

Spouse birth date: (we have a special birthday program): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

In the event of an emergency: Whom should we contact \_\_\_\_\_

Relation to you: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Referred by: (Friend) (Relative) (Doctor) (Newsletter) (mailer) (other: \_\_\_\_\_)

Which one of our patients or our doctor friends should we thank for referring you? \_\_\_\_\_

## Reason for Visit . . . . .



Please circle your current symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Shoulder Pain)

(Arthritis) (Low Back Pain) (Lyme's Disease) (Sinus Problems) (Cold or Flu)

(Low Back Pain) (Hip / Pelvis Pain) (Asthma or Allergies) (Numbness) (Sciatic)

(Digestive) (Hormonal) (Stomach) (Macular Degeneration) (Diabetes)

(Cancer) (Cardiovascular) (Chemical Toxicity) (Skin or Acne)

Other: \_\_\_\_\_

My symptoms are due to: (Auto accident) (Work accident) (Slip and fall)  
(Gradual Onset) (Family History) (My symptoms are chronic)

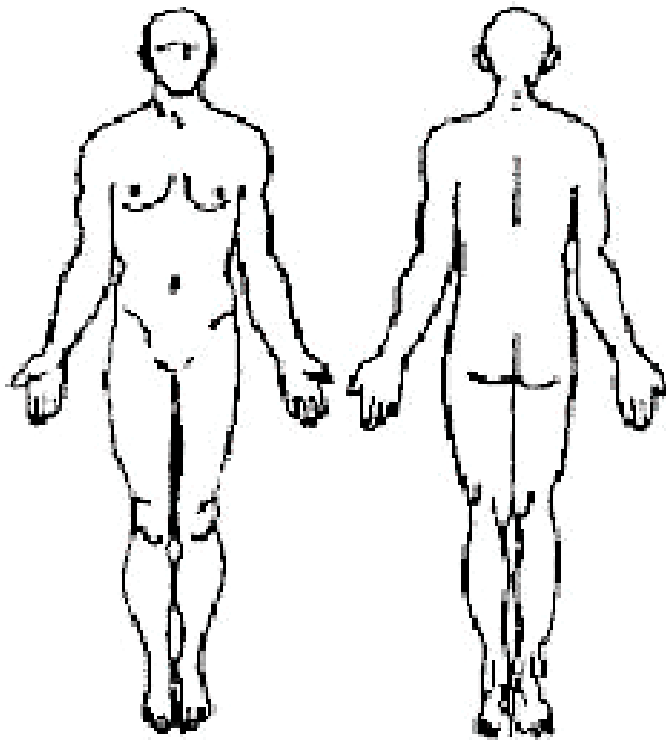
The reason for the visit is (please circle):

(I am in pain) (Chiropractic) (Acupuncture) (Prolozone) (IV therapy) (Nutrition Consult)

(Hormone Consult) (Microscope Evaluation) (BioResonance Testing) (Weight Loss)

(Asthma or Allergies) (Cancer options)

**Welcome  
to our  
Practice!**



Please mark the area of pain or problematic concern.

Patient Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List the major symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the Rx you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Please list any vitamins, minerals or herbs you are taking: \_\_\_\_\_  
\_\_\_\_\_

Other doctors you have seen for this condition: \_\_\_\_\_  
\_\_\_\_\_

Do you have a pacemaker?

List any significant surgeries: \_\_\_\_\_  
\_\_\_\_\_

## Symptom Checklist

4

When the symptom/pain start?

\_\_\_\_\_

What makes it feel better (ice/heat/aspirin/rest etc.)

\_\_\_\_\_

What makes it feel worse (movement, heat, standing, sitting)

\_\_\_\_\_

What does it feel like (sharp, throb, ache, numb etc.)

\_\_\_\_\_

Does the pain travel anywhere (up the arm, down the leg)

\_\_\_\_\_

Does it hurt more in the AM or PM?

\_\_\_\_\_

Any other medical history or conditions the doctor should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any of the following?

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> HIV          | <input type="checkbox"/> Chicken pox   | <input type="checkbox"/> Epilepsy        |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Measles      | <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> Polio           |
| <input type="checkbox"/> Mumps        | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> STD             |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Whooping Cough  |

### Significant Past Medical History

Have you been hospitalized?  Yes  No

Reason: \_\_\_\_\_

Does your father have health conditions?  Yes  No

\_\_\_\_\_

Does your mother have health conditions?  Yes  No

\_\_\_\_\_

Do you siblings have health conditions?  Yes  No

\_\_\_\_\_

\_\_\_\_\_

Do you drink alcohol?  Yes  No

Do you smoke?  Yes  No

Do you eat consistently?  Yes  No

Do you go to the bathroom consistently?  Yes  No

Do you eat breakfast?  Yes  No

We bill your insurance as a COURTESY to you. Benefits vary from company to company and policy to policy. We will file your insurance however, you are responsible to see that they pay. You are responsible to keep your account current. You also agree to personally responsible for payment of all services rendered., whether it is for you're a dependent.

We don't participate with all insurances. Please help understand verify your insurance before we start treatment.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portion of my medical records. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, auto-med, third party liability, and other health plans to THE WEST CLINIC (initial: \_\_\_\_\_)

Deductibles - for those patients that have deductibles we do our best to determine your current deductible. For those persons not meeting deductible or if we are not able to determine the deductible, we require a DEPOSIT to be made. Once the deductible has been determined an account can be credited or refunded.

INITIAL \_\_\_\_\_

In the past we have submitted to insurance and billed the patient for the difference. If you request this step we will have to do the following:

1. Charge \$7.80 per statement per month
2. Charge 18% interest on unpaid balances.

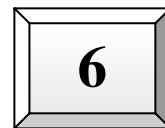
INITIAL \_\_\_\_\_

## Insurance Information

Name as it appears on the insurance card: \_\_\_\_\_

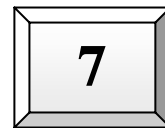
Insured's Name: \_\_\_\_\_

Insured's Date of Birth



## Office Policies

If I am accepted as a patient at the West Clinic, I agree to pay for all services, including services not covered by my insurance. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account. .



## Financial Policy

We invite you to discuss with us any questions regarding our services. The best health services are based upon friendly, mutual understanding between provider and patient.

The West Clinic cannot be a lending institution and payment is required at the time of service. For those who have insurance coverage, the West Clinic will accept payment from the insurance entity toward the amount of the bill. I understand that I will personally be responsible for the balance; patients that do not have or refuse to place a credit card on file are required to provide a deposit of the office visit balance at the time of service.

Because of the difficulty of determining insurance deductibles and co-payments, the office requires a credit card on file for charges for co-payments and deductibles. Clinic policy does not allow account balances in excess of \$250.

Non-covered services such as:

- Body Casts
- Acupuncture
- Neural therapy
- Intravenous Therapy
- Injection Therapy
- Vitamins, minerals, herbs
- Hormone Tests

must be paid the day of service unless prior arrangements are made. Exceptions are personal injury and workers' comp claims.

We do have the ability to make payment arrangements should you so need.

Unpaid balances:

Balanced older than 30 without payment are subject to a \$5.00 per statement and 18% interest. Balances older than 90 days will be sent to collections and assessed a \$25 collection fee.

We realize that temporary financial problems may affect timely payment. If such problems arise, we encourage you to call us for assistance in the management of your account.



I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize the treating health care provider(s) to proceed with any necessary treatment. I have read the West Clinic policies and consent to treat information, and I agree with them by signing below:

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

Print Name: \_\_\_\_\_

Parent /Guardian Signature: \_\_\_\_\_