W. Scott West, M.D., PLLC
30 Burton Hills Blvd., Suite 375
Nashville, TN 37215
Phone 615-327-4877 Fax 615-327-4881
http://healthymindsnashville.com

Patient Information :

Last Name: _____ First: _____ MI: _____

Prefers to be called (if different from legal name): _____

Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _______________ Age: _____ Sex: MALE / FEMALE

Social Security #: _____-_____-_____ (not required for minors)

Who referred you to Dr. West? _____

Personal Information:
Spouse's Name: _____ Phone: _____

Patient Employer/Occupation: _____Phone: _____

Emergency Contact: _____ Phone: _____

Electronic Mail (EMAIL) Policy:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature and please contact the office if you have not received a reply within 24 hours.

*I have read and agree to the terms of the email policy X_____

Email address: _____

W. Scott West, M.D.
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Payment Policy:

Payment is required in full at the time of service. We accept credit/debit/checks/cash (please note we do not keep change in the office for cash payments but are happy to put a credit on your account if you do not have exact cash).

* For your convenience we can keep a credit card on file to charge at your appointments.

Credit/Debit Card Payment for appointments:

I/we authorize W. Scott West, M.D. to bill the above credit/debit card for professional services at the time of service. I will notify W. Scott West, M.D. in writing if I no longer want my credit/debit card billed. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date: _____

Credit/Debit Card Payment for missed or cancelled appointments:

I authorize W. Scott West, M.D. to charge the above credit/debit card when the patient does not give advance notice for a late-cancellation or no-show appointments. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date: _____

_____ Visa _____ Master Card _____ Discover _____ AMEX

Name on Card: _____ **Security Code:** _____
Billing Zip Code _____
Card #: _____
Exp. Date _____

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Insurance Policy:

As an out of network provider we are not contracted with any insurance companies and we do not accept payment from insurance companies. As a courtesy we can file your insurance for you, however, any reimbursement will be paid directly to you from your insurance company. Please note, we CAN NOT file your insurance for you until all payment is received. This policy includes commercial insurance plans as well as traditional Medicare plans. We do not bill any Medicare Advantage plans but can provide you with the detailed receipt if you wish to file it yourself. It is the patient's responsibility to update their insurance with the office if there are any changes. Reimbursement from your insurance company is based on your individual out of network benefits. Filing your insurance is not a guarantee of payment or reimbursement by your insurance company. You can get detailed benefit information by contacting your insurance company directly.

Appointment Charges / Cancellation Policy:

We do not overbook appointments and appointments made are reserved for the patient. We require a **24-hour cancellation notice**. Patients will be charged the full session rate if they do not cancel an appointment within the 24-hour time frame or if they fail to keep their appointment on the day it is scheduled. If you need to change or reschedule an appointment, please call our office as soon as you can so we can accommodate other patients who wish to be seen.

Office Hours:

Dr. West's office hours are by appointment Monday through Friday. The front office is open Monday through Thursday 9am – 4pm and Friday 9am – 2pm. If you need to contact the office regarding an appointment, billing questions or for general needs please call during these hours.

If you need to speak with your doctor between office visits, please call the office 9am-4pm. We will be able to get a message to your doctor asking him to call you back.

Medication refill policy:

Medication refill requests require a 24 hour notice. If medication refills are required between appointments, please have your pharmacy fax us a refill request. If you need to call for a refill you can do so Monday through Thursday 9am-4pm and Friday 9am-12 noon. Refills will be communicated to your pharmacy within 24 hours during regular business hours. After hours and weekend requests may not be called in until the next business day. Please call with your prescription information and dosage as well as your pharmacy name, location and phone number. We will need this information to complete your refill request.

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After Hour Emergencies:

To reach your doctor after office hours call the main office at 615-327-4877 and press 0 to be connected to our answering service. You may hear silence while the line connects. They will page your doctor or the on-call doctor for any urgent needs you may have after hours. If you are experiencing an emergency and cannot wait, please call 911.

Termination of Treatment:

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your doctor.

Consent to Treatment and Patient Financial Responsibility:

- I have read the policies listed above and I understand and agree to them. I agree to be treated by W. Scott West, M.D., and when necessary, any doctors covering in his absence.

- I authorize W. Scott West, M.D. to release any information my insurance company requests or requires concerning patient care regarding billing or prescription needs.

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges for services rendered. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that unpaid balances over 90 days are past due and may be referred to a collection agency.

Patient's Signature: _____

Date: _____

Person Responsible for Payment - (complete only if the patient is NOT paying for the bill):

Name of person responsible for bill: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____

Date of Birth: _______________ SS#: _____

HIPAA Privacy Rule
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement

- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness_____

Printed Name of Individual or Legal Representative _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ Individual refused to sign
☐ Communication barrier prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Others (please specify)

_____

Notice of Privacy Practices
(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include completing a prior authorization for medication on your behalf through your insurance company and pharmacy.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review (a health insurance company's opportunity to review a request for medical treatment). An example of this would be sending a bill for your visit to your insurance company for payment or communication with your insurance company regarding treatments you have received or requested that have been billed to them.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may communicate with you by email through an encrypted email system as referenced in your new patient paperwork.

We may call your name in the waiting area which could be overheard by others.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to your provider:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. You may request a written copy of the Notice of Privacy Practices from this office at any time.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing and complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D. C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775