Russ Canfield MD
Board Certified, Family Medicine
& Integrative Holistic Medicine

66 Avenida Aldea
Santa Fe NM 87507
Phone (505) 795-7111
Fax (505) 795-7112
www.360medicine.com

Improving all aspects of Your Health

Nursing IV Clinic Intake Packet

Our cutting edge outpatient medical practice is directed by Dr. Russ Canfield, who is Board Certified in both Family Medicine and Integrative Holistic Medicine and has over 15 years of independent practice experience. Patients with an uncomplicated health history and normal lab tests can receive nutritional IVs in our practice after an intake visit with one of our registered nurses. Our RN's are also available to provide lifestyle and nutritional education services. We maintain a natural medicine dispensary on site to assist in achieving wellness.

We are an out-of-network physician with respect to health insurance. To submit an out-of-network insurance claim, the client mails our invoice with a claim form directly to his or her insurance company. Claim forms can be obtained by contacting your insurance company and can often be downloaded from the company's website.

Our practice has opted out of Medicare. Although Medicare will not reimburse for office visits, Medicare will cover lab work, X-rays and other tests ordered by Dr. Canfield.

Appointments are made by calling the office phone weekdays between 9am and 5pm. Please give us at least 24 hours notice if you need to cancel an appointment.

Charges for IV therapy are dependent upon the IV to be administered. Payment is due at the time of service. A $20 service charge is assessed on any account balance after 30 days. The returned check fee is $30. We accept Visa, MasterCard and American Express.

Many of our clients are chemically sensitive. Please come to your appointment fragrance free. We ask that you make copies of your recent lab work for your initial visit, including a CBCD and CMP results. If you have not had these labs tested within the last three months, we can draw these labs for you prior to initiating IV therapies. We also ask that all IV therapy patients come well hydrated and with a light snack.

We look forward to seeing you in the clinic.

I have read and understand the above clinic policies and procedures.

_____ _____

Patient Signature Date

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Demographic Information

Name _____ How did you hear about us? _____

Preferred first name _____ Date of birth _____

Street address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____ Fax _____

E-mail _____ Would you like to receive a future e-mail newsletter? Yes___ No___

Patient's employer _____ Tel # _____

Employer street address _____ City _____ State _____ Zip _____

Patient's occupation _____ are you a Veteran? Yes___ No___

Marital status: Single Married Partner W Sep D Spouse/partner name _____

Telephone: Home _____ Office _____ Cell _____

Emergency contact _____ Tel # _____ Relationship _____

Physician's Name_____ Tel#_____Fax#_____

BILLING PREFERENCE

_____ (Our preferred option)

Please keep my credit card information on file. It will be kept strictly confidential.

Card type (please circle one) VISA MASTERCARD AMEX

Name as it appears on card _____

Card number _____

3-digit code (4 for AMEX on front) on reverse of card _____

Expiration Date _____ Billing address zip code _____

_____ Please bill me at the time of service.

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Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Russell Canfield MD, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Russell Canfield MD, PC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Russell Canfield MD, PC reserves the right to revise its Notice of Privacy Practices at any time. To obtain a revised Notice of Privacy Practices, send a written request to Russell Canfield MD, PC.

With this consent, **Russell Canfield MD, PC may call** my home or an alternative location and leave a message on voice mail or with a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, clarifying insurance information and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Russell Canfield MD, PC may mail or e-mail** to my home or an alternative location these and other items that assist the practice in carrying out TPO.

With this consent, **Russell Canfield MD, PC may disclose my PHI to other health care providers involved in my care** for purposes related to my medical treatment.

Your protected health information may be disclosed in the form of a "limited data set" for research, public health, and health care operations. A "limited data set" does not contain any direct identifiers of individuals (e.g. should not include name, address, phone number, social security number, etc.), but may contain any other demographic or health information needed for public health research or health care operations purposes.

I have the right to request that Russell Canfield MD, PC restrict how it uses or discloses my PHI in carrying out TPO.

By signing this form, I am consenting to allow Russell Canfield MD, PC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian, if applicable *Date*

_____

Print Name of Patient or Legal Guardian

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Required Medicare Part B Private Services Contract

This is a contract between L. R. Canfield MD ("Physician"), and_____ ("Patient"), who resides at_____ and is currently a Medicare Part B beneficiary or may become a Medicare Part B beneficiary in the future, who is seeking services now or in the future covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Physician has informed Patient that Physician has elected to opt out of the Medicare program effective 04/01/06.

- I, L. R. Canfield MD, have not been excluded from Medicare under Sections 1128, 1156 or 1892 of the Social Security Act.
- I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Dr. Canfield.
- I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Dr. Canfield may charge for items or services furnished.
- I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Dr. Canfield to submit a claim to Medicare.
- I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Dr. Canfield that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- The current effective date of the opt-out period is 04/01/2014 and 04/01/2016. This contract remains in effect for as long as Dr. Canfield extends the current opt-out period.
- I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)
- I the Medicare beneficiary or my legal representative will or have received a copy or photocopy of this contract before items or services are furnished to me under its terms.
- I, L. R. Canfield MD, will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.
- Physician will supply CMS with a copy of this contract upon request.
- I, L. R. Canfield MD, understand that the current opt-out period is for two years. If I again opt-out of Medicare, I will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

_____ _____ _____ _____
(Physician's Signature) (Date) (Patient's Signature) (Date)

_____ _____ _____ _____
(Patient's Legal Representative Signature) (Date) (Witness) (Date)

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Medical Symptom Questionnaire

Name _____ Date of Birth _____

Health concerns (i.e. weight, fatigue, pain, anxiety, heart problems, pain etc.):

_____

_____

_____

Health goals (i.e. more energy, better sleep, balanced mood etc.):

_____

_____

_____

Rate each of the following symptoms based upon your typical health over the past 30 days.

Point Scale

0 *Never* or *almost never* have the symptom
1 *Occasionally* have it, effect is *not severe*
2 *Occasionally* have it, effect is *severe*
3 *Frequently* have it, effect is *not severe*
4 *Frequently* have it, effect is *severe*

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia Total _____

EYES
_____Swollen, reddened or sticky eyelids
_____Blurred or tunnel vision
(does not include near or far-sightedness)
_____Bags or dark circles under eyes
_____Watery or itchy eyes Total _____

EARS
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss
_____Itchy ears Total _____

NOSE
_____Excessive mucus formation
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Stuffy nose Total _____

MOUTH
_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen or discolored tongue, gums, lips
_____Canker sores Total _____

SKIN
_____Acne
_____Hives, rashes, dry skin
_____Hair loss
_____Flushing, hot flashes
_____Excessive sweating Total _____

HEART
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain Total _____

LUNGS
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing Total _____

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DIGESTIVE
_____Nausea, vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching, passing gas
_____Intestinal/stomach pain
_____Heartburn Total _____

JOINTS/MUSCLES
_____Pain or aches in joints
_____Pain or aches in muscles
_____Stiffness or limitation of movement
_____Feeling of weakness or tiredness
_____Arthritis Total _____

WEIGHT
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____Underweight Total _____

ENERGY/ACTIVITY
_____Restlessness
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity Total _____

MIND
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Poor physical coordination
_____Difficulty in making decisions
_____Stuttering or stammering
_____Slurred speech
_____Learning disabilities Total _____

EMOTIONS
_____Mood swings
_____Anxiety, fear, nervousness
_____Anger, irritability, aggressiveness
_____Depression Total _____

OTHER
_____Frequent or urgent urination
_____Genital itch or discharge
_____Frequent illness Total _____

*GRAND TOTAL*_____

Personal Health Information

Please check only those items that apply, and feel free to provide more specifics as appropriate

FEMALE
Date of last period _____
Problems with periods _____
Pelvic pain _____
Excessive bleeding _____
Birth control type _____
Breast tenderness _____
Urinary incontinence _____

MALE
Prostate problems _____
Scrotal pain _____
Frequent urination _____

PSYCHOLOGICAL Describe your mood
__Happy __Calm __Safe __Optimistic
__Depressed __Anxious __Angry __Afraid

Stress level __Low __Medium __High
Average nightly hours of sleep _____
What brings you joy/meaning?
_____

SOCIAL
Connected/supported? Yes__ Somewhat__ No__
Type of job _____
Enjoy your work? Yes__ Somewhat__ No__

FAMILY *Circle your relationship status*
Single Married Separated Divorced Partner
Same Sex Partner Widow/Widower
Number of children _____ Ages _____

HABITS
Tobacco- smoke or chew _____

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Alcohol _____drinks per week
Coffee _____cups per day
Tea _____cups per day
Illicit drugs _____
Aerobic exercise _____
Weight training _____
Relaxation/Meditation _____

DIET

	Frequent	*Often*	*Seldom*	*Never*
Eat at restaurants	_____	_____	_____	_____
pastries/cookies/sweets	_____	_____	_____	_____
fish/poultry	_____	_____	_____	_____
beef/lamb/pork	_____	_____	_____	_____
milk/cheese	_____	_____	_____	_____
salads	_____	_____	_____	_____
grains	_____	_____	_____	_____
beans/legumes	_____	_____	_____	_____

MEDICAL CONDITIONS

__Diabetes __Accident/Injury
__Hypertension __Cancer
__Heart disease __Osteoporosis
Other:
_____
_____
_____

SURGERIES ***DATES***

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
Any metal plates/rods/screws? Yes ___ No___

FAMILY MEDICAL HISTORY

Diabetes _____
Hypertension _____
Cancer; what types? _____
Alzheimer's Disease _____
Heart problems _____
Arthritis _____
Other _____

DATES OF MEDICAL TREATMENT

Pap smear _____
Mammogram _____
Rectal exam _____
EKG _____
Bone density test _____
Test for blood in stool _____
Colonoscopy/sigmoidoscopy _____

MEDICATIONS, HERBS, SUPPLEMENTS

Please list medications and supplements taken regularly with doses if known:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES and SENSITIVITIES

Medications _____
Foods _____
Animals _____
Pollens _____
Chemicals/Mold _____

CURRENT PAIN LEVEL (1-none, 5-very high)

1 2 3 4 5

Explain: _____

OVERALL HEALTH STATUS

Excellent Good Average Declining Debilitated

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Principles of Holistic Medical Practice

- Unconditional love is life's most powerful healer. Physicians strive to adopt an attitude of unconditional love for patients, themselves, and other practitioners.
- Optimal health is much more than the absence of sickness. It is the conscious pursuit of the highest qualities of the spiritual, mental, emotional, physical, environmental and social aspects of the human experience, and the awareness of being fully alive.
- Illness is viewed as a manifestation of a dysfunction of the whole person, not as an isolated event.
- Holistic physicians embrace a variety of safe, effective options in diagnosis and treatment, including education for lifestyle changes and self-care; complementary approaches; and conventional drugs and surgery.
- Searching for the underlying causes of disease is preferable to treating symptoms alone.
- Holistic physicians expend as much effort in establishing what kind of patient has a disease as they do in establishing what kind of disease a patient has.
- Prevention is preferable to treatment and is usually *more* cost-effective. The *most* cost-effective approach evokes the patient's own innate healing capabilities.
- A major determinant of healing outcomes is the quality of the relationship established between physician and patient, in which patient autonomy is encouraged.
- The ideal physician-patient relationship considers the needs, desires, awareness and insight of the patient as well as those of the physician.
- Physicians significantly influence patients by their example.
- Illness, pain and the dying process can be learning opportunities for patients and physicians.
- Holistic physicians encourage patients to evoke the healing power of love, hope, humor and enthusiasm and to release the toxic consequences of hostility, shame, greed, depression and prolonged fear, anger and grief.

ADOPTED BY THE AMERICAN HOLISTIC MEDICAL ASSOCIATION 1993