

Russ Canfield, MD  
Medical Director  
Board Certified, Family Medicine  
Practicing Integrative Holistic Medicine



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

## Practice Information, Policies and Procedures

We are an innovative medical clinic directed by Russ Canfield MD who is Board Certified in Family Medicine with over 20 years of clinical experience practicing Integrative Medicine. We implement a multidimensional, multidisciplinary approach to health and healing in order to achieve integral wellness. Our center is able to deliver the highest quality comprehensive medical care by assessing your health concerns from multiple angles simultaneously. Each client is treated as an individual with an effort to understand the underlying antecedent causes of your particular health situation as well as its triggers. We emphasize a strong healing partnership between you and our staff in order to skillfully roll out a personalized medical treatment program with you.

Patients with a relatively uncomplicated health history and normal lab tests may receive nutritional and detoxification services at our practice, including IVs, after an intake visit with our registered nurse. Our RN and health coach are also available to provide weight loss and nutritional education services. We maintain a cost competitive natural medicine dispensary on site stocked with high quality nutritional supplements to assist you in achieving wellness. We tend to recommend a solid foundation of lifestyle, nutritional, detoxification and energetic self-care practices and interventions. Stronger and more directed therapeutics, including targeted pharmaceuticals, are employed in more challenging conditions.

Dr. Russell Canfield and Dr. Stephen Weiss are both out-of-network physician with respect to all health insurance plans and may cross-cover for each other. To submit an out-of-network insurance claim, the client mails our invoice with a claim form directly to the insurance company. We have opted out of Medicare. Although Medicare will not reimburse for our care, Medicare will cover labs, x-rays and other tests we order, as long as they are deemed medically necessary by Medicare. Generally, HMO Medicare Advantage plans and New Mexico Medicaid do not allow a non-participating physician to order labs and diagnostic tests, however.

Appointments are made by calling the office on weekdays between 9am and 5pm. Please give us at least 24 business hours notice if you are an existing patient and need to cancel an appointment, and 48 business hours notice if you are a new patient to avoid being charged a cancellation fee. We require that you have your pharmacy fax us with routine medication refill requests. When lab tests are ordered, we schedule a follow-up appointment to thoughtfully discuss the results of your studies and any needed adjustments to your treatment plan.

Physician charges for Dr. Canfield are \$540 for a 90 minute visit, \$360 for a 60 minute visit, \$180 for a 30 minute visit and \$90 for a 15 minute visit. Most physician injections are \$80 per region, but PRP and biologic product injection costs differ considerably. Due to the ever increasing number and complexity of medication and procedure prior authorizations, we charge \$30 for a prior auth. Nursing visits are charged at \$100/hour. Our services menu outlines the rates for medical treatments administered by our nursing staff. These rates are subject to change. Payment is due at the time of service. Tax is not included in these costs. A \$30 service charge is assessed on any account balance after 30 days. The return check fee is also \$30. We accept Visa, MasterCard, Discover, and AMEX.

Many clients like the convenience of telephone or e-mail consultations directly with their doctor. Dr. Canfield can be reached after hours on his mobile (505) 980-4812 or at russcanfield@360medicine.com. In the case of telephone calls, the regular rates apply and will usually be charged to the client's credit card. E-mails are charged based on time spent composing the response. There is no charge for straightforward issues that are handled in a brief call. The *Telephone/E-Mail Consultation Agreement* outlines the specifics of this service.

Many of our clients are chemically sensitive. Please come to your appointment fragrance free. It is very helpful to us if you can make copies of your recent lab work for your initial visit. We look forward to seeing you in the clinic.

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

\_\_\_\_\_

Print Name of Patient or Legal Guardian

\_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_

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 Spouse/partner name \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_

Emergency contact \_\_\_\_\_ Tel # \_\_\_\_\_ Relationship \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Address \_\_\_\_\_

Tel # \_\_\_\_\_ Fax # \_\_\_\_\_

### **Insurance Information** *(Needed to authorize some diagnostic tests and non-formulary medications)*

Are you eligible for Medicare? \_\_\_ Yes \_\_\_ No

Name of insured person (if not patient) \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Tel # \_\_\_\_\_

Insurance Company name \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Tel # \_\_\_\_\_

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## Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Russell Canfield MD, PC/Stephen P. Weiss MD, PA 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/Stephen P. Weiss MD, PA 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/ Stephen P. Weiss MD, PA 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/ Stephen P. Weiss MD, PA 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/Stephen P. Weiss MD, PA 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/Stephen P. Weiss MD, PA 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.

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*Print Name of Patient or Legal Guardian*

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*Signature of Patient or Legal Guardian*

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*Date*

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### Medicare Opt Out Contract

*Dr. Lawrence Russell Canfield is not a Medicare provider and is exempt from providing Medicare coverage effective under sections 1128, 1156, or 1892 of the Social Security Act.*

**By signing this contract, you agree to the following:**

*As either a patient or as a patient's legal representative, I \_\_\_\_\_, accept full responsibility for payment of charges for all services furnished by Dr. Lawrence Russell Canfield.*

*I understand that Medicare limits do not apply to what Dr. Lawrence Russell Canfield or his staff may charge for items or services furnished by Dr. Lawrence Russell Canfield.*

*I agree not to submit a claim to Medicare or any Medicare Advantage Plan. I will not ask Dr. Lawrence Russell Canfield or his staff to submit a claim to Medicare or any Medicare Advantage Plan.*

*I understand that Medicare payment will not be made for any items or services furnished by Dr. Lawrence Russell Canfield that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.*

*I understand that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare. 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.*

*I also 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.*

\_\_\_\_\_  
*Patient Signature* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Patient's Legal Representative (If applicable)* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Dr. Lawrence Russell Canfield signature* \_\_\_\_\_  
*Date*

**Medicaid Opt Out Contract:** *As either a patient or as a patient's legal representative, I \_\_\_\_\_, accept full responsibility for payment of charges for all services furnished by Dr. Lawrence Russell Canfield. Dr. Lawrence Russell Canfield is not a participating provider with New Mexico Medicaid and does not accept Medicaid as payment for medical services. If I am a patient who is or becomes eligible for New Mexico Medicaid, I understand that I have the right to seek treatment with another provider that accepts New Mexico Medicaid. I or my legal representative agree to be held financially responsible for payment for services rendered by L. R. Canfield MD or their staff.*

\_\_\_\_\_  
(Physician's Name)      \_\_\_\_\_  
(Physician's Signature)      \_\_\_\_\_  
(Date)      \_\_\_\_\_  
(Patient's Signature)      \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Patient's Legal Representative Signature)      \_\_\_\_\_  
(Date)      \_\_\_\_\_  
(Witness)      \_\_\_\_\_  
(Date)

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## Telephone Consultations, E-Mails and Clerical Services

Client Name \_\_\_\_\_ DOB \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

- I may reach Dr. Canfield on his cell phone (505-980-4812) to speak with him immediately, or have my call returned promptly.
- I may reach Dr. Canfield via e-mail at russcanfield@360medicine.com. I understand he or his assistant will respond to my e-mail within 24 hours.
- I understand that telephone consultations and e-mails are charged at regular office rates, based on time involved. I understand I will be charged only for calls I initiate, or when the doctor calls me back in response. When Dr. Canfield initiates a call or e-mail to ask how I am doing, there is no charge.
- There is no charge for most refill requests faxed to us directly from your pharmacy. We do charge \$20 for controlled substance refills that require special documentation, refills that need to be phoned into a new pharmacy and urgent medication requests.

### 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    DISCOVER

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.

This agreement is subject to any restriction I request.

(Example: *The doctor should reach me only on my cell phone number.*)

Restriction(s): \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If you would like a copy of this agreement, please ask us and a copy will be provided to you.

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## Medical Symptom Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

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

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Use the point scale below to rate each of the following symptoms based upon your typical health over the past 30 days.

- 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 \_\_\_\_\_

\_\_\_\_ Swollen or discolored tongue, gums, lips  
\_\_\_\_ Canker sores  
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 \_\_\_\_\_

**SKIN**  
\_\_\_\_ Acne  
\_\_\_\_ Hives, rashes, dry skin  
\_\_\_\_ Hair loss  
\_\_\_\_ Flushing, hot flashes  
\_\_\_\_ Excessive sweating  
Total \_\_\_\_\_

**EARS**  
\_\_\_\_ Earaches, ear infections  
\_\_\_\_ Drainage from ear  
\_\_\_\_ Ringing in ears, hearing loss  
\_\_\_\_ Itchy ears  
Total \_\_\_\_\_

**HEART**  
\_\_\_\_ Irregular or skipped heartbeat  
\_\_\_\_ Rapid or pounding heartbeat  
\_\_\_\_ Chest pain  
Total \_\_\_\_\_

**NOSE**  
\_\_\_\_ Excessive mucus formation  
\_\_\_\_ Sinus problems  
\_\_\_\_ Hay fever  
\_\_\_\_ Sneezing attacks  
\_\_\_\_ Stuffy nose  
Total \_\_\_\_\_

**LUNGS**  
\_\_\_\_ Chest congestion  
\_\_\_\_ Asthma, bronchitis  
\_\_\_\_ Shortness of breath  
\_\_\_\_ Difficulty breathing  
Total \_\_\_\_\_

**MOUTH**  
\_\_\_\_ Chronic coughing  
\_\_\_\_ Gagging, frequent need to clear throat  
\_\_\_\_ Sore throat, hoarseness, loss of voice

**DIGESTIVE**  
\_\_\_\_ Nausea, vomiting  
\_\_\_\_ Diarrhea  
\_\_\_\_ Constipation  
\_\_\_\_ Bloating feeling  
\_\_\_\_ Belching, passing gas  
\_\_\_\_ Intestinal/stomach pain  
\_\_\_\_ Heartburn  
Total \_\_\_\_\_



