Russ Canfield, MD
Medical Director
Stephen Weiss MD
Independent Contractor Staff Physician
Board Certified, Family Physicians
Practicing Integrative Holistic Medicine


66 Avenida Aldea
Santa Fe NM 87507
Phone (505) 438-0668
Fax (505) 795-7112
www.360medicine.com

*Improving all aspects of Your Health*

## 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. Weiss are $412.50 for a 90 minute visit, $343.75 for a 75 minute visit, $275 for a 60 minute visit, $137.50 for a 30 minute visit and $69.00 for a 15 minute visit. Due to the ever increasing number and complexity of medication and procedure prior authorizations, we charge $25 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.

Dr. Weiss does not provide after-hours consultations. If a problem arises after normal business hours or on Friday, Saturday, or Sunday and you need medical attention, please go to Urgent Care or the nearest emergency room. Dr. Weiss's patients taking homeopathic remedies will be given specific instructions about after-hours homeopathic coverage at the time of their office visit.

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___

Parent's employer _____ Tel # _____

Employer street address _____ City _____ State _____ Zip _____

Parent's occupation _____

Parent's 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.

| _____ | _____ | _____ |
|---|---|---|
| *Print Name of Patient or Legal Guardian* | *Signature of Patient or Legal Guardian* | *Date* |

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# Medicare Opt Out Contract

*Dr. Stephen Weiss 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. Stephen Weiss.*

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

*I agree not to submit a claim to Medicare or any Medicare Advantage Plan. I will not ask Dr. Stephen Weiss 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. Stephen Weiss 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. Stephen Weiss 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. Stephen Weiss. Dr. Stephen Weiss 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 Stephen Weiss 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 Albuquerque calling area cell phone (505-980-4812) and speak with him immediately, or have my call returned promptly. Dr. Weiss may only be reached during office hours Monday -Thursday only.
- I may reach Dr. Canfield via e-mail at russcanfield@gmail.com. Dr. Weiss may only be reached via e-mail at 360physician@gmail.com during office hours Monday thru Thursday only.
  I understand he or his assistant will respond to my e-mail within 24 hours.
  This e-mail service is not via an encrypted server; therefore, I understand that these e-mails are not totally protected.
- 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 or Dr. Weiss 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, wheezing, anxiety, heart problems, pain etc) :

_____

_____

Health goals (i.e. more energy, less allergies, balanced mood etc) :

_____

_____

Rate each of the following symptoms based upon your child's 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
_____Difficulty falling asleep
_____Wakes up during the night Total _____

***EYES***
_____Swollen, reddened or sticky eyelids
_____Bags under eyes
_____Dark circles under eyes
_____Watery or itchy eyes Total _____

***EARS***
_____Earaches, ear infections
_____Reddening of ears
_____Drainage from ear
_____Hearing loss
_____Frequent pulling on ears
_____Itchy ears Total _____

***NOSE***
_____"Allergic Salute" (rubs, itches, wipes nose frequently with hands)
_____Runny nose
_____Sneezing
_____Stuffy nose Total _____

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

***SKIN***
_____Easy bruising
_____Hives
_____Rash
_____Dry or flaky skin
_____Cold hands or feet
_____Eczema Total _____

***LUNGS***
_____Coughing
_____Sneezing
_____Difficulty breathing
_____Wheezing Total _____

***DIGESTIVE***
_____Nausea
_____Vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching
_____Passing gas (flatulence)
_____Tummy ache
_____Heartburn
_____Poor appetite
_____Refusal to eat Total _____

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***JOINTS/MUSCLES***
_____Pain in joints (e.g. knee ache)
_____Pain in muscles (e.g. leg ache)
_____Coordination Problems Total _____

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

***MIND/EMOTIONS***
_____Inattention or poor concentration
_____Mood swings
_____Anxiety, nervousness
_____Fear
_____Anger
_____Irritability
_____Aggressiveness (e.g. hitting, kicking, biting)
_____Crying of weepiness
_____Tantrums
_____Hyperactivity Total _____

***OTHER***
_____Frequent urination
_____Itching of anus or genitals
_____Bed wetting
_____Wetting or soiling of clothes Total _____

*GRAND TOTAL*_____

## Pediatric Health Information

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

***BIRTH & MEDICAL HISTORY***
Is the child yours by:
__birth __adoption __stepchild other:_____
Birth weight: _____ length: _____
List problems during pregnancy or delivery:
_____
_____
Birthplace _____
List problems during newborn period:
_____
_____
List significant medical problems since infancy:
_____
_____

At what age did your child: walk_____ talk_____
Has your child had: __chickenpox __meningitis
__mumps __rubella __measles __tuberculosis
List any hospitalizations or surgeries:
_____
_____
_____
Broken bones or severe sprains:
_____

***VACCINATIONS***
Is your child immunized?_____
Do you have concerns about the vaccine schedule?
_____

***GIRLS***
Date of first period _____
Date of last period _____
Excessive bleeding _____
Any birth control? _____

***PSYCHOLOGICAL***
Describe child's mood:
__Happy __Calm __Safe __Optimistic
__Depressed __Anxious __Angry __Afraid
Child's stress level: __Low __Medium __High

***SCHOOL***
Does your child attend preschool/school?
__no __yes
Any concerns about school performance?
_____
Any concerns about relationships at school?
_____

**SOCIAL**
Child care: __parents others: _____
Who lives at home? (name, age, relationship)
_____
_____
_____
Are the child's parents __married __unmarried
__separated __divorced, when?_____
Mother's occupation _____
Father's occupation _____
Religion/spirituality _____

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***HABITS***

Any unusual feeding or dietary problems?

_____

Has your child had any sleep problems?

_____

Do you live in an older home that may contain lead?_____
Do any household members smoke?_____
Has your child been to the dentist?_____
Do you drink unfiltered city water? _____
Number of hours per day your child spends with:
TV_____ computer_____ video games_____
Exercise _____
Hobbies/interests _____

| ***DIET*** | *Frequent* | *Often* | *Seldom* | *Never* |
|---|---|---|---|---|
| Eat at restaurants | ____ | ____ | ____ | ____ |
| pastries/cookies/sweets | ____ | ____ | ____ | ____ |
| fish/poultry | ____ | ____ | ____ | ____ |
| beef/lamb/pork | ____ | ____ | ____ | ____ |
| milk/cheese | ____ | ____ | ____ | ____ |
| vegetables/salads | ____ | ____ | ____ | ____ |
| grains | ____ | ____ | ____ | ____ |
| beans/legumes | ____ | ____ | ____ | ____ |

***MEDICAL CONDITIONS***

__Asthma __Allergies
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 _____

***MEDICATIONS, HERBS, SUPPLEMENTS***

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

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

***SAFETY***

Does the child always use:
a bike/skiing/skateboarding helmet? __yes __no
a car seat/seatbelts? __yes __no
a lifejacket around water? __yes __no
Is violence at home a concern to you? __no __yes
Is there a gun in your home? __no __yes
If so, is it locked? __no __yes

***ALLERGIES and SENSITIVITIES***

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

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

1 2 3 4 5

Explain:_____