Russ Canfield MD
Medical Director

360° Medicine.

Improving all aspects of your health

Board Certified Family Medicine
Practicing Integrative Holistic Medicine

Practice Information, Policies and Procedures

We are an innovative medical clinic directed by Russ Canfield MD who is Board Certified in both Family Medicine and Integrative Holistic Medicine with over 15 years of clinical experience. 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 is 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. Canfield is an out-of-network physician with respect to all health insurance plans. 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.

Appointments are made by calling the office on weekdays between 9am and 5pm. Please give us at least 24 hours notice if you need to cancel an appointment. 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 are $450 for a 90 minute visit, $300 for a 60 minute visit, $150 for a 30 minute visit and $75 for a 15 minute visit. Most physician injections are $80 per region. 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. A $30 service charge is assessed on any account balance after 30 days. The return check fee is also $30. We accept Visa, MasterCard 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@gmail.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 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.

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

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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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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.
- I may reach Dr. Canfield via e-mail at russcanfield@gmail.com.
- I understand he 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 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

Name as it appears on card _____

Card number _____

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

Expiration Date _____ Billing address zip code _____

☐ Please bill me at the time of service.

This agreement is subject to any restriction I request.
(Example: *Dr. Canfield 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.):

_____

_____

_____

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

_____

_____

_____

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 _____

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. 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 _____

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HABITS

Tobacco- smoke or chew _____
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/butter	___	___	___	___
vegetables/salads	___	___	___	___
bread/pasta/cereal	___	___	___	___
beans/legumes	___	___	___	___

MEDICAL CONDITIONS

___Diabetes ___Arthritis
___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 _____

MEDICATIONS, HERBS, SUPPLEMENTS

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

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

ALLERGIES & 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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