



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 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



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 # _____



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



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)



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.)



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 | 3 Frequently have it, effect is not severe |
| 1 Occasionally have it, effect is not severe | 4 Frequently have it, effect is severe |
| 2 Occasionally 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 _____



DIGESTIVE

- ___ Nausea, vomiting
 - ___ Diarrhea
 - ___ Constipation
 - ___ Bloating 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 _____



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

	<i>Frequent</i>	<i>Often</i>	<i>Seldom</i>	<i>Never</i>
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