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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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
_____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
_____Ear aches, 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
_____Wheezing
_____Difficulty breathing Total _____

DIGESTIVE
_____Nausea
_____Vomiting
_____Diarrhea
_____Constipation

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DIGESTIVE continued
_____Bloated feeling
_____Belching
_____Passing gas (flatulence)
_____Tummy ache
_____Heartburn
_____Poor Appetite
_____Refusal to eat Total _____

JOINTS/MUSCLES
_____Pain in joints (e.g. knee ache)
_____Pain in muscles (e.g. Leg ache)
_____Coordination problems Total _____

ENERGY/ACTIVITY
_____Restlessness
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____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 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? ☐ Yes ☐ No
Any concerns about school performance?
_____
Any concerns about relationships at school?
_____

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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 _____

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/seat-belts?	☐ Yes	☐ No
a lifejacket around water?	☐ Yes	☐ No
Is violence at home a concern to you?	☐ Yes	☐ No
Is there a gun in your home?	☐ Yes	☐ No
If so, is it locked?	☐ Yes	☐ No

ALLERGIES & SENSITIVITIES

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

CURRENT PAIN LEVEL (1-none, 5-very high)
1 2 3 4 5
Explain:_____

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