

Russ Canfield MD  
Board Certified, Family Medicine  
& Integrative Holistic Medicine



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

*Improving all aspects of Your Health*

## **Practice Information, Policies and Procedures**

I am a cutting edge outpatient physician, Board Certified in both Family Medicine and Integrative Holistic Medicine with over a decade of clinical experience. My goal is to deliver the highest quality medical care by approaching health from every angle while also emphasizing a strong doctor-patient partnership. I tend to recommend a foundation of lifestyle, nutritional and energetic interventions and use stronger pharmaceutical medication in the more challenging conditions. I treat each client as an individual. We arrive at treatment decisions together.

I am an out-of-network physician with respect to health insurance. To submit an out-of-network insurance claim, the client mails my invoice with a claim form directly to his or her insurance company. Claim forms can be obtained by contacting your insurance company and can often be downloaded from the company's website.

I have opted out of Medicare. Although Medicare will not reimburse for visits to my office, Medicare will cover lab work, X-rays and other tests ordered by me.

Appointments are made by calling the office phone weekdays between 9am and 5pm. Please give us at least 24 hours notice if you need to cancel an appointment. Dr. Canfield can be reached after hours on his Albuquerque calling area cell phone (505) 980-4812 or via e-mail at russcanfield@gmail.com. Generally, we prefer that clients have their 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.

Charges are \$420 for a 90 minute visit, \$280 for a 60 minute visit, \$140 for a 30 minute visit and \$70 when a 15 minute visit is all that is needed. Our current rates are subject to change. Payment is due at the time of service. A \$20 service charge is assessed on any account balance after 30 days. The return check fee is \$30. We accept Visa, Mastercard and American Express.

Many clients lead busy lives and like the convenience of telephone or e-mail consultations directly with their doctor. 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 labwork for your initial visit.

We look forward to seeing you in the clinic.

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

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Patient Signature

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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 W Sep D Spouse/partner name \_\_\_\_\_

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

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

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

If known, 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 \_\_\_\_\_

Insurance Company address \_\_\_\_\_

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.

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*Signature of Patient or Legal Guardian, if applicable*

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*Date*

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*Print Name of Patient or Legal Guardian*

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### Telephone Consultations, E-Mails and Clerical Services

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

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

- 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-mail messages 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.
- On the infrequent occasions when cell phone service goes down, I understand I may call an alternate number to reach Dr. Canfield at his home (505-466-4577).
- We do not charge for refill requests faxed directly from your pharmacy. We do charge \$20 for refills that need to be personally phoned into a new pharmacy as well as 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 (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: *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) :

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

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Rate each of the following symptoms based upon your typical health over the past 30 days.

*Point Scale*

- |   |   |
|---|---|
| <b>0</b> Never or almost never have the symptom     | <b>3</b> Frequently have it, effect is not severe |
| <b>1</b> Occasionally have it, effect is not severe | <b>4</b> Frequently have it, effect is severe     |
| <b>2</b> Occasionally have it, effect is severe     |   |

### HEAD

\_\_\_\_ Headaches  
\_\_\_\_ Faintness  
\_\_\_\_ Dizziness  
\_\_\_\_ Insomnia  
Total \_\_\_\_\_

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

### DIGESTIVE

\_\_\_\_ Nausea, vomiting

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\_\_\_ 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, and 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



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## **Principles of Holistic Medical Practice**

- Unconditional love is life's most powerful healer. Physicians strive to adopt an attitude of unconditional love for patients, themselves, and other practitioners.
- Optimal health is much more than the absence of sickness. It is the conscious pursuit of the highest qualities of the spiritual, mental, emotional, physical, environmental and social aspects of the human experience, and the awareness of being fully alive.
- Illness is viewed as a manifestation of a dysfunction of the whole person, not as an isolated event.
- Holistic physicians embrace a variety of safe, effective options in diagnosis and treatment, including education for lifestyle changes and self-care; complementary approaches; and conventional drugs and surgery.
- Searching for the underlying causes of disease is preferable to treating symptoms alone.
- Holistic physicians expend as much effort in establishing what kind of patient has a disease as they do in establishing what kind of disease a patient has.
- Prevention is preferable to treatment and is usually *more* cost-effective. The *most* cost-effective approach evokes the patient's own innate healing capabilities.
- A major determinant of healing outcomes is the quality of the relationship established between physician and patient, in which patient autonomy is encouraged.
- The ideal physician-patient relationship considers the needs, desires, awareness and insight of the patient as well as those of the physician.
- Physicians significantly influence patients by their example.
- Illness, pain and the dying process can be learning opportunities for patients and physicians.
- Holistic physicians encourage patients to evoke the healing power of love, hope, humor and enthusiasm and to release the toxic consequences of hostility, shame, greed, depression and prolonged fear, anger and grief.