

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.

Parent Signature

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 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)*

Is your child 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.

Signature of Parent or Legal Guardian

Date

Print Name of Parent or Legal Guardian

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Telephone/E-Mail Consultation Agreement

Client Name _____ DOB _____

Street Address _____

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).

BILLING PREFERENCE

____ 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 (please print) _____

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): _____

Parent 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 | 3 Frequently have it, effect is <i>not</i> severe |
| 1 Occasionally have it, effect is <i>not</i> severe | 4 Frequently have it, effect is severe |
| 2 Occasionally 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

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- ___ Constipation
 - ___ Bloating 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

- ___ 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 fully 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?

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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 a home built before 1972? _____
 Do any household members smoke? _____
 Has your child been to the dentist? _____
 Do you drink 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	_____	_____	_____	_____
grains	_____	_____	_____	_____
beans/legumes	_____	_____	_____	_____

MEDICAL CONDITIONS

Asthma Allergies
 Other: _____

SURGERIES

DATES

_____	_____
_____	_____
_____	_____
_____	_____
Any metal plates/rods/screws?	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 helmet? yes no
 a helmet, pads & wrist guards when rollerblading/skateboarding? yes no
 car seat/seatbelts? yes no
 a lifejacket around water? yes no
 sunscreen when in the sun? 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: _____

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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.