

Russ Canfield, MD
Medical Director
Stephen Weiss MD
Independent Contractor Staff Physician
Board Certified, Family Physicians
Practicing Integrative Holistic Medicine



66 Avenida Aldea
Santa Fe NM 87507
Phone (505) 795-7111
Fax (505) 438-0668
www.360medicine.com

Practice Information, Policies and Procedures

We are an innovative medical clinic directed by Russ Canfield MD who is Board Certified in Family Medicine with over 20 years of clinical experience practicing Integrative Medicine. 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 and health coach are 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. Russell Canfield and Dr. Stephen Weiss are both out-of-network physician with respect to all health insurance plans and may cross-cover for each other. 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, as long as they are deemed medically necessary by Medicare. Generally, HMO Medicare Advantage plans and New Mexico Medicaid do not allow a non-participating physician to order labs and diagnostic tests, however.

Appointments are made by calling the office on weekdays between 9am and 5pm. Please give us at least 24 business hours notice if you are an existing patient and need to cancel an appointment, and 48 business hours notice if you are a new patient to avoid being charged a cancellation fee. 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 for Dr. Weiss are \$412.50 for a 90 minute visit, \$343.75 for a 75 minute visit, \$275 for a 60 minute visit, \$137.50 for a 30 minute visit and \$69.00 for a 15 minute visit. Due to the ever increasing number and complexity of medication and procedure prior authorizations, we charge \$25 for a prior auth. 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. Tax is not included in these costs. A \$30 service charge is assessed on any account balance after 30 days. The return check fee is also \$30. We accept Visa, MasterCard, Discover, and AMEX.

Dr. Weiss does not provide after-hours consultations. If a problem arises after normal business hours or on Friday, Saturday, or Sunday and you need medical attention, please go to Urgent Care or the nearest emergency room. Dr. Weiss's patients taking homeopathic remedies will be given specific instructions about after-hours homeopathic coverage at the time of their office visit.

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/Stephen P. Weiss MD, PA 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/Stephen P. Weiss MD, PA 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/ Stephen P. Weiss MD, PA 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/ Stephen P. Weiss MD, PA 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/Stephen P. Weiss MD, PA 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/Stephen P. Weiss MD, PA 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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Medicare Opt Out Contract

Dr. Stephen Weiss is not a Medicare provider and is exempt from providing Medicare coverage effective under sections 1128, 1156, or 1892 of the Social Security Act.

By signing this contract, you agree to the following:

As either a patient or as a patient's legal representative, I _____, accept full responsibility for payment of charges for all services furnished by Dr. Stephen Weiss.

I understand that Medicare limits do not apply to what Dr. Stephen Weiss or his staff may charge for items or services furnished by Dr. Stephen Weiss.

I agree not to submit a claim to Medicare or any Medicare Advantage Plan. I will not ask Dr. Stephen Weiss or his staff to submit a claim to Medicare or any Medicare Advantage Plan.

I understand that Medicare payment will not be made for any items or services furnished by Dr. Stephen Weiss that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I understand that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare. 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.

I also 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.

Patient Signature

Date

Patient's Legal Representative (If applicable)

Date

Dr. Stephen Weiss signature

Date

Medicaid Opt Out Contract: *As either a patient or as a patient's legal representative, I _____, accept full responsibility for payment of charges for all services furnished by Dr. Stephen Weiss. Dr. Stephen Weiss is not a participating provider with New Mexico Medicaid and does not accept Medicaid as payment for medical services. If I am a patient who is or becomes eligible for New Mexico Medicaid, I understand that I have the right to seek treatment with another provider that accepts New Mexico Medicaid. I or my legal representative agree to be held financially responsible for payment for services rendered by Stephen Weiss MD or their staff.*

(Physician's Name) (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 _____

- Dr. Weiss may only be reached during office hours Monday - Thursday only by either calling the clinic or via e-mail at frontdesk@360medicine.com during office hours Monday - Thursday.
I understand he or his assistant will respond to my e-mail within 24 hours.
- 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. Weiss 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 DISCOVER

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: *The doctor 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 _____
____ 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
____ Chronic coughing
____ Gagging, frequent need to clear throat
____ Sore throat, hoarseness, loss of voice
DIGESTIVE
____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloating feeling
____ Belching, passing gas
____ Intestinal/stomach pain
____ Heartburn Total _____

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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? _____

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 _____

SOCIAL

Connected/supported? Yes__ Somewhat__ No__

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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	_____	_____	_____	_____

EKG _____
 Bone density test _____
 Test for blood in stool _____
 Colonoscopy _____

MEDICAL CONDITIONS

Diabetes Arthritis
 Hypertension Cancer
 Heart disease Osteoporosis
 Other: _____

MEDICATIONS, HERBS, SUPPLEMENTS

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

SURGERIES

DATES

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any metal plates/rods/screws? Yes _____ No _____

FAMILY MEDICAL HISTORY

Diabetes _____
 Hypertension _____
 Cancer; what types? _____
 Alzheimer's Disease _____
 Heart problems _____
 Arthritis _____
 Other _____

ALLERGIES and SENSITIVITIES

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

CURRENT PAIN LEVEL (1-none, 5-very high)

1 2 3 4 5

Explain: _____

DATES OF MEDICAL TREATMENT

Pap smear _____
 Mammogram _____
 Rectal exam _____

OVERALL HEALTH STATUS

Excellent Good Average Declining Debilitated