STEPHEN P. WEISS, M.D., P.A.

www.HolisticMedicineHeals.com
3901 Georgia Street NE, Suite D
Albuquerque, NM 87110
(505) 872-2611

Welcome to our office. Our goal is to offer you the absolute highest quality of healthcare and medical services by blending the best of Western and Alternative Medicine. We encourage our patients to make health a priority. The patients that benefit most from our care are those who are willing to make changes in their lives and allow us to guide them toward a more total integration of physical, emotional and spiritual health.

ABOUT DR. STEPHEN P. WEISS

Dr. Weiss is board certified in Family Practice since 1990, has extensive post-graduate training and incorporates homeopathy, herbal medicine, nutrition, emotional and spiritual counseling, and lifestyle modification in his Holistic Integrative Practice. He believes that the best medicine enhances the body's natural ability to heal itself. For this reason, homeopathic remedies and herbal and nutritional supplements are his first lines of treatment when appropriate. He also uses traditional therapies and medications when necessary, as well as performing wellness exams and annual gynecological check-ups.

PATIENT INFORMATION

During your first visit and time permitting, our providers will review your complete medical history, address concerns, and order lab tests if necessary. Please bring the new patient forms, and recent lab tests, MRIs/X-Rays and other relevant tests to your appointment, a complete list of supplements/medications, including dosages, and a list of any specialists you have seen pertaining to your health concerns.

FEE SCHEDULE

(Prices does not include tax)

New Patient Visits			***Follow-Up Visits***		
60 minutes	*-*	*$279*	*30 minutes*	*-*	*$135*
			60 min	*-*	*$269*

If your visit extends beyond the times listed above, you will be charged accordingly, on a prorated basis. The same fees apply for all phone, email or written consultations.

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Please read the office policy below. ***Initial and sign*** *to indicate that you have read, understand and agree to adhere to our policies. Bring this form to your first appointment.*

FINANCIAL POLICY

_____*All services rendered must be paid in full at time of service. We accept cash, check, American Express, Discover, MasterCard, and VISA. The return check fee is $35.*

APPOINTMENTS

_____*We are a self pay office and patients are billed on the amount of time spent with the provider. This is different from other providers who accept insurance. Insurance companies determine how practitioners charge their patients and this is often the reason for shorter or rushed appointments. We are not within the same regulation as many other practitioners and this is why the level of care our patients receive is so much higher.*

_____ *Our Providers make every effort to stick to the time allotted for your appointment, but due to the complexity of the patients we see and the challenges of tailoring an individualized Integrative Medicine program for each patient, sometimes this is not possible. We make every effort to address all of your most pressing health concerns during each visit. Please let our Providers know if it is imperative that we stick to the allotted time, even if it means we may not be able to tie everything together during that particular appointment.*

CANCELLATION POLICY

_____***We have a 24 hour cancellation policy*** *for established patients. If you cancel or miss an appointment without 24-hour notice, you will be billed in-full for the visit.* ***For new patient visits we require 2 BUSINESS DAYS (48 hours) notice.*** *Please note we are closed on Fridays. Monday appointments must be cancelled the Wednesday prior to avoid a fee.*

NEW PATIENT DEPOSIT

_____*A $75 down payment is required for new patients, in order to book your first appointment. This is necessary due to the fact that over the years, we have experienced a number last minute cancellations and a long wait list for patients in need of an appointment. The remaining balance for your first visit will be paid at the time services are provided. If you cancel your appointment in accordance with our above cancellation policy, we will refund your $75. If you miss your appointment, you forfeit your down payment. Established patients are not subject to down payments for visits.*

OUT OF STATE PATIENTS

_____*Patients who do not reside in New Mexico must be seen in the office for a minimum initial 90-120 minute consultation, and at least once a year in office thereafter. Follow-ups may be done by phone in many instances.*

INSURANCE

_____*Your medical insurance is a contract between you and your insurance company to which we are not a party.* ***We do not accept insurance****; however, many plans pay a percentage of the visit, after you have met your deductable, if you have out-of-network coverage. We will provide you with a form to file for reimbursement.*

MEDICARE

_____*We are not Medicare providers, therefore you cannot bill Medicare for services. Lab work and radiology services are generally covered by Medicare if there is medical necessity.*

WORKERS COMPENSATION

_____*We do not accept Workers' Compensation and are not contracted with any insurance company. Check with your insurance carrier as many insurance plans do cover a portion of our fees.*

TELEPHONE/EMAIL CONSULTATIONS & INQUIRIES

_____*Any patient, who has a brief 2-3 minute question regarding their last appointment, will not be charged. For example, a request for a clarification on a recommendation, medication, supplement or homeopathic instructions qualifies as a brief question. This policy applies to all calls, faxes and emails made to office staff. If you have a single, complex question or concern, or numerous questions or concerns, you will be asked to schedule an appointment.*

All other patients who have questions or inquiries requiring medical expertise will be charged a minimum of $25, with a prorated amount, charged at regular office visit rates, depending on the amount of time the provider spent on your inquiry. This includes reading emails, letters, composing responses, reports, filling out medical forms for disability, research requests, therapies, etc. A minimum fee of $15 applies for supplement prescriptions for FSA plans if done outside an office visit.

PRESCRIPTION REFILLS

_____*Please call your pharmacy with all prescription refill requests, when you have 7-10 days of medication left. Your pharmacy will contact us. Once they contact us, it will take 24-48 hours to process the request. Some refills will require an office visit, if this is the case, we will notify you. We must see you in the office at least once a year in order to refill your prescriptions.*

EMERGENCIES/AFTER HOURS & WEEKEND COVERAGE

_____*Our practice is an out-patient practice. We do not see or follow patients in the hospital. Medical problems requiring admission to a hospital will be referred to hospital-based physicians. 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.

CLASSICAL HOMEOPATHY (Dr. Weiss's patients only)

_____*Some patients will be treated with homeopathic remedies, either by request or because Dr. Weiss believes it is most likely to help with your medical problem(s). Because Dr. Weiss is an M.D., these patients will have a 1 hour Initial Visit to perform a regular history and physical. Then, a 60-90 minute Classical Homeopathy appointment will be booked. After that appointment, the patient will need to be seen in 4 weeks for an additional 30 minute follow-up. It is crucial to assess your progress and adjust your remedy if needed. If a problem arises in between visits, please contact the office for advice. Also, please refrain from using any other homeopathic medicine or alternative treatments, unless you have cleared it with us. If it has been over a year since your last dental check-up, we suggest seeing your dentist, as dental work should be completed before you begin homeopathic care.*

Classical Homeopathy is particularly time consuming because there are several thousand existing remedies that Dr. Weiss has to choose from to find the one remedy that matches the totality of your symptoms. The cost of homeopathic remedies is extremely affordable and can partially offset the cost of the consultation.

PERFUME OR COLOGNE

_____*We ask that on the day of your appointment that you do not wear perfume, cologne, or scented lotion. Many of our patients are allergic or chemically sensitive.*

HIPAA

_____*The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. HIPAA states that there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office medical services.*

Your information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, and laboratories.

We do not share records electronically and are not considered a covered entity under HIPPA's requirements. However, it is our policy to keep patient information confidential. Files may be temporarily left in open racks and will not contain any coding which identifies a patient's condition or information. Patient records will not be available to persons other than office staff.

We agree to provide patients with access to their records in accordance with state/federal laws. We reserve the right to change the terms of this notice and our policies at any time.

Please sign below, indicating that you agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

I, _____, date _____ hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that my consent remains in force from this time forward.

MEDICAL RECORDS

_____*We require a signed, written request from the patient to release medical records. The request can be mailed to 3901 Georgia St. NE Suite D, Albuquerque, NM 87110 or faxed to 505-830-4648. Please contact our office for possible fees.*

As mandated by the New Mexico Medical Board, we keep all patient files for 10 years. For minors, we keep records 10 years from the age of 21.

Thank you for reading and understanding our office policy. Please let us know if you have any questions. Our intention is to serve the community as best we can with the safest and most effective treatments available. ***Your personal referrals are greatly appreciated.***

*Name*_____ *Signature*_____ *Date*_____

*Parent/Responsible Party Signature*_____ *Relationship to Patient* _____

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Pediatric Information Sheet

*Name of Patient: _____ Sex: **M / F** DOB: _____*

Parent/Guardian Name: _____ Relationship to child: _____

Guarantor's Social Security Number:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Emergency Contact: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

How did you hear about us? _____

If you were referred, whom should we thank for referring you?_____

Insurance Information

Name of Insured: _____ Relationship (circle one): Self Spouse Child

Insurance Company: _____ Phone: _____

Policy or ID Number: _____ Group Number: _____

Medical History

(Circle one)
*Has your child ever used homeopathy or herbal remedies? **Y / N***

If yes, what remedies? _____

*Has your child ever seen a Naturopathic physician, Chiropractor, Acupuncturist or other alternative healthcare provider? **Y / N** If yes, which/who:_____*

Pediatrician/Specialists _____

Are vaccinations up to date? ***Y / N*** *If no, explain:*_____
(If possible provide vaccination schedule)

Any reactions to vaccinations? ***Y/ N*** *If yes, explain:* _____

Does your child have food sensitivities? ***Y/ N***

If yes, to what foods? _____

Is your child receiving dental care? ***Y/ N*** *Date of last exam?* _____

Is/was your child breast fed? ***Y/ N*** *For how long?* _____

Is/was your child formula fed? ***Y/ N*** *What Brand?* _____

Any known allergies to foods, animals, herbs or other substances? Please list allergen and reaction:

_____

_____

Does your child now, or in the past, experience(d) the following?: (Circle all that apply)

Anemia	*Blood clotting disorder*	*Ear infections*	*Thrush or Candida*
Hepatitis	*HIVor AIDS*	*Blood transfusions*	*Teething difficulties*
Bladder infections	*Chickenpox*	*Thyroid disease*	*Sleep disturbances*
Hernia	*Asthma*	*Hives or Eczema*	*Behavioral issues*
Bleeding tendency	*Epilepsy*	*Gastroesophgeal Reflux (GERD)*	*Other* _____

How would you describe your child's overall health? (Circle one)

Excellent *Good* *Average* *Fair* *Poor*

Pregnancy/Delivery History

Was this birth a normal delivery? ***Y / N*** *If not, explain*_____

Duration of pregnancy: _____ *Birth weight:* _____

Any drugs taken during pregnancy? (Include prescription, recreational drugs and over the counter):

_____

_____

Any alcohol? ***Y/ N*** *If yes, how much?* _____

Pregnancy/Delivery History Continued

Any tobacco? ***Y/ N*** *If yes, how much?* _____

High blood pressure? ***Y/ N***

Illness/Infections/Injuries during pregnancy? _____

Delay in respiration or cry? ***Y/ N*** *Apgar score, if known?* _____

Was oxygen administration necessary? ***Y/ N***

Did your child have any of the following as a newborn? (Circle all that apply)

Jaundice	*Cyanosis (blue discoloration due to lack of oxygen)*	*Anemia*
Seizures		*Infection*

Other important conditions _____

Illnesses/Injuries and Hospitalizations/Surgeries/ER visits

1. Age _____ Reason: _____

2. Age _____ Reason: _____

3. Age _____ Reason: _____

Any history of head injury? ***Y/ N*** *If yes, explain:* _____

Has your child ever been unconscious? ***Y/ N*** *If yes, explain:* _____

Has your child ever had seizures? ***Y/ N*** *If yes, explain:* _____

Development

(Write age beside development)

Smile _____ *Pulled to stand* _____

Crawled _____ *First words* _____

Laughed out loud _____ *Walked around furniture*_____

*Walked unassisted*_____ *Rolled over* _____

Completed sentences _____ *Sat without support* _____

Rode bicycle _____ *Toilet trained* _____

First put words together ("bye-bye" or "Daddy") _____

Family Medical History

(Indicate which family member, if known)

Mental retardation _____ *Cerebral palsy* _____

Seizures _____ *Paralysis* _____

Migraines _____ *Headaches* _____

Depression/Mental disorders _____ *Any other neurological condition:*

Movement disorders _____ _____

Other significant Family History:

_____

_____

_____

School Assessment

(According to parents)

Grade level _____ *Achievements* _____

Reading level _____ _____

Motivation _____ *Eyesight* _____

Behavior _____ *Hearing* _____

Attention _____ *Motor coordination* _____

Relationship with teachers/peers _____ *Speech* _____

Any learning problems? _____

Miscellaneous

What is the MAIN reason for seeing us today? If there is a specific problem, describe it in detail, including the first time you noticed the condition. List factors you suspect may have played a role in its onset and continuation:

_____

_____

_____

_____

_____

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MEDICARE OPT OUT CONTRACT

(If child is on Medicare through disability)

Dr. Weiss is not a Medicare provider and is exempt from providing Medicare coverage Effective ***October 1, 2015 through October 1, 2017*** *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. Weiss.

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

I agree not to submit a claim to Medicare or to ask Dr. Weiss or his staff to submit a claim to Medicare.

I understand that Medicare payment will not be made for any items or services furnished by Dr. 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 understands 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) *Relationship*

_____ _____

Dr. Stephen P. Weiss *Date*

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Medication List

List any prescription MEDICATIONS you are taking, include strength, dosage & frequency of use (Please use an additional sheet if necessary):

- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____

List any over-the-counter drugs (i.e. Tylenol, Advil), vitamins & herbal supplements. Include strength, dosage & frequency of use. Please use an additional sheet if necessary.

- _____ • _____ • _____
- _____ • _____ • _____
- _____ • _____ • _____
- _____ • _____ • _____
- _____ • _____ • _____

List any drug allergies:

_____

_____

_____

*Name*_____ *Signature*_____ *Date*_____

*Parent/Responsible Party Signature*_____ *Relationship to Patient* _____