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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Welcome to our office. Please fill out our patient history form and bring it with you to your first appointment so that we can review it. This allows us to provide you with the best, most comprehensive care possible. All information is confidential and will only be released with your permission.

Please list the problems you would like addressed and how long you have had them.

_____

_____

_____

_____

_____

_____

_____

_____

_____

What kind of treatments, if any, you have tried?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Patient Information Sheet

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age:_____ Date:_____ Sex: (Circle One) ***M / F***

Social Security Number:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____ Marital Status: _____

Emergency Contact: _____

Race:

- ☐ *Hispanic*
- ☐ *Asian*
- ☐ *Native American*
- ☐ *African American*
- ☐ *White*
- ☐ *Other*

Occupation_____

Primary Physician: _____Phone:_____Fax:_____

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: _____

Is this a Worker's Compensation Claim: ***Y / N***

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MEDICARE OPT OUT CONTRACT

Dr. Weiss is not a Medicare provider and is exempt from providing Medicare coverage Effective ***October 1, 2017 through October 1, 2019*** *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 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) *Relationship*

_____ _____
Dr. Stephen P. Weiss *Date*

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Medication List

List any doctor prescribed 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* _____

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Women - Patient History

Height _____Weight_____ Change in weight in last year? ***Y / N*** *Amount? _____lbs.*

Are you pregnant? ***Y / N / Unsure***

Date of Last: Pap smear _____ Normal _____ Abnormal _____

Date of Last: Mammogram _____ Normal _____ Abnormal _____

Date of Last: Thermogram _____ Normal_____ Abnormal _____

Do you have osteoporosis or osteopenia (circle one)? ***Y / N*** *Date of diagnosis _____*

Date of last bone density test:_____

Date of last Colonoscopy_____ Normal____Abnormal___

Do you consider yourself generally Healthy? ***Y / N*** *Do you snore at night?* ***Y / N*** *CPAP:* ***Y / N***

Do you have sleep apnea? ***Y / N*** *Any cardiac events?* ***Y / N*** *Date:_____*

Explain: _____

If any lab tests were performed within the last year, please bring these results to the consultation if possible.

From the following, please CIRCLE any past or current medical problems for YOURSELF.

High blood pressure
Alcohol/Drug Abuse
Alzheimer's
Blood disorders
Anxiety, Depression
Hearing problems
Stroke
Chronic fatigue syndrome
Lupus
Anemia
Seizure disorder
Skin disorders
Heart disease
Ulcers
Frequent bladder infections
Blood clots in legs or lungs
Irritable bowel syndrome
Colon Cancer
High Cholesterol
Gallbladder disease/gallstones
Breast Cancer
Diabetes
Hemorrhoids
Ovarian / Cervical cancer
Kidney disease
Hepatitis
Polycystic ovaries (PCOS)
Lung disease, asthma, TB
Osteoporosis/Osteopenia
Uterine Fibroids
Migraine headache
Thyroid disorder
Other Cancer
Fibromyalgia
Arthritis
Allergies
Rheumatic fever
Birth defects
Thyroid disease
Emphysema
Epilepsy
Sexually transmitted disease
Glaucoma
Other_____

Family Medical History

Mother: _____

Father: _____

Siblings: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Surgeries

Year	*Nature of Surgery*	*Comment*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Gynecological History

First day of last period _____ *Is menstrual pain/cramping a problem for you?* ***Y / N***

Any spotting/bleeding between periods? ***Y / N*** *Or year of your last period (menopause)* _____

Have you had a hysterectomy? ***Y / N*** *Do you still have your: ovaries?* ***Y / N*** *Cervix?* ***Y / N***

Are you presently using birth control? ***Y / N*** *If yes, what type*_____ *How long* _____

*Are you sexually active with: Male(s)?*_____ *Female(s)?*_____ *Both?*_____ *Not sexually active*_____

If yes, is sex satisfactory? ***Y / N***

Do you have a history of sexual, physical or emotional abuse? ***Y / N***

Have you ever been on hormone therapy? ***Y / N*** *If yes, when?*_____ *Type?*_____

Are you still on hormone Therapy? ***Y / N*** *Satisfied with results?* ***Y / N***

Have you ever been diagnosed with any kind of breast disease? ***Y / N*** *If yes, explain:*_____

_____

Obstetrical History

How many pregnancies have you had? _____ How many children do you have? _____

How many live births have you had? _____ Have you had trouble maintaining a pregnancy? ***Y / N***

Do you consider yourself generally physically fit? ***Y / N***

What type(s) of exercise do you do?_____

How often and how much do you exercise? _____

Do you currently smoke or chew tobacco? ***Y / N*** *If yes, how many packs per day? _____*

Did you smoke in the past? ***Y / N*** *If yes, year started:_____ # of years? _____ # per day_____*

Is alcohol or drug use a problem for you? ***Y / N*** *If yes, explain:_____*

How much Alcohol do you consume daily? _____oz. (hard liquor) _____glass (wine) ____cans of beer

Social drinker? ***Y / N***

Stress

How would you rate your stress level?

Least *Greatest*

O----------O----------O----------O----------O

1 2 3 4 5

How long have you had this amount of stress? Years_____ Months_____

What do you do to relieve stress?: _____

Are you a "care giver"? ***Y / N*** *Explain:_____*

Have you had a recent major stress (i.e. loss of job, loss of loved one, change in marital status)? ***Y / N***

Explain: _____

Have you been recently diagnosed with any major health issues? ***Y / N***

If yes, explain: _____

Do you have any physical or emotional disabilities? ***Y / N***

If yes, explain:_____

What type of personality are you? Calm_____ Emotional_____ Hyper_____ Worry all the time_____

Are you satisfied with your life? ***Y / N*** *Are you happy?* ***Y / N*** *Problems sleeping?* ***Y / N***

Is spirituality or religion important in your life? ***Y / N***

Explain:_____

Typical Diet per Day

Please record servings (serving = approx. 4 oz.) for each category of food which has been consumed during a typical day. Also note your mood when you eat and how many ounces of water you drink.

Breakfast	***Noon***	***Dinner***	***Snack***
P_____	*P_____*	*P_____*	*P_____*
C_____	*C_____*	*C_____*	*C_____*
F&V_____	*F&V_____*	*F&V_____*	*F&V_____*

(P = protein C = Carbohydrate F&V = fruits & vegetables)

Mood_____	*Mood_____*	*Mood_____*	*Mood_____*
	(G=good, D=depressed, I=irritable, A=Anxious)		
Water (oz.) _____	*Water (oz.) _____*	*Water (oz.) _____*	*Water (oz.) _____*

Eat fish_____ x per week *Eat beef _____ x per week* *Eat Chicken _____ x per week*

Do you have any dietary restrictions/ preferences? _____

Do you drink juices such as apple, orange? ***Y / N*** *Do you juice fruits & vegetables:* ***Y / N***

Do you drink carbonated beverages? ***Y / N*** *How many per day: _____*

Do you drink "Diet" beverages? ***Y / N*** *How many per day: _____*

How many cups of Coffee or Tea per day? _____ *Caffeinated_____ Decaf_____*

Do you know the difference between a "low" and "high" glycemic index food? ***Y / N***

List food allergies: _____

Are you currently on a weight loss diet? ***Y / N*** *If so, describe: _____*

How many pounds have you lost? _____ *Over what time frame? _____*

Review of Systems: Check if you have problems with the following:

____Chest Pain	*____Indigestion*	*____Bleeding Problems*
____Constipation	*____Skin Rashes*	*____Fatigue*
____Muscle Pain	*____Anxiety*	*____Back Pain*
____Shortness of Breath	*____Gas*	*____Memory Problems*
____Diarrhea	*____Acne*	*____Leg Swelling*
____Urinating	*____Headaches*	*____Joint Pain*
____Aggression	*____Heartburn*	*____Insomnia*

Other:

_____

If you do not want a hormone consult, skip this page

SYMPTOM LIST……IMPROVE YOUR AWARENESS……FOR WOMEN

The following symptoms may be associated with hormonal changes. Check and give a relative value to the symptom identified if applicable to start. Symptoms will be reassessed after 30-60 days of therapy.
(S = slight, M =moderate, E = excessive)

ESTROGEN	*Start*	*30 days*
Hot Flashes	____	____
Night Sweats	____	____
Vaginal Dryness (painful intercourse)	____	____
Water Retention	____	____
Memory Lapse	____	____
Sleep Problems	____	____
Headaches	____	____
Incontinence	____	____
Thinking problems	____	____
Menstrual Bleeding	____	____
Depression	____	____
Continuous Fatigue	____	____
Weight Gain	____	____
Wrinkles around mouth, eyes, cheeks	____	____
Irritable	____	____
Loss of scalp hair	____	____
Bone Loss	____	____
Heart palpitations	____	____
PROGESTERONE		
Tender breasts	____	____
Nervousness/Anxiety	____	____
Fibrocystic breasts	____	____
Thick uterine lining(excessive bleeding)	____	____
Uterine fibroids	____	____
Mood swings/irritability	____	____
Premenstrual tension (PMS)	____	____
DHEA		
Dry eyes	____	____
Poor pubic hair	____	____
Noise sensitivity	____	____
Excess body odor	____	____
CORTISOL		
Sugar cravings	____	____
Fibromyalgia	____	____
Increased aches & pains	____	____
Increased allergies	____	____
Inability to handles stress	____	____
Salt cravings	____	____

THYROID	*Start*	*30 days*
Morning Fatigue	____	____
Hypertension	____	____
Nocturnal Cramps	____	____
Morning hoarseness	____	____
Dry Skin	____	____
Diffuse Hair Loss	____	____
Morning Stiffness	____	____
Low Back Pain	____	____
Carpel tunnel syndrome	____	____
Sensitive to cold	____	____
Poor Circulation	____	____
Constipation	____	____
Puffy Face	____	____
Partial eyebrows	____	____
Thin brittle striated nails	____	____
Edema hands, face, eyelids	____	____
Low body temperature	____	____
TESTOSTERONE		
Increase facial/body hair	____	____
Acne, greasy hair	____	____
Lack of self assurance	____	____
Decrease muscle strength	____	____
Tired all the time	____	____
Aggressive behavior	____	____
Decrease libido/sex drive	____	____
GROWTH HORMONE		
Evening fatigue	____	____
Fatty cushions above knee	____	____
Dropping triceps	____	____
Sagging facial cheeks	____	____
Thin lips/skin	____	____
Decrease muscle strength	____	____
Light sleep	____	____
Low self-esteem	____	____
Poor wound healing	____	____
MELATONIN		
Early graying	____	____
Light anxious sleep	____	____