NORTHERN SUN
FAMILY HEALTH CARE

SARAH ACKERLY, N.D., CPM CARRIE WERNER, N.D., MIDWIFE

Welcome to Northern Sun Family Health Care! We hope you find your patient experience healing, informative, and restorative.

The following questions of the form will help Dr. Ackerly and Dr. Werner assess and treat you in the weeks to come. Please fill out the paperwork as thoroughly as possible.

In order to maintain the highest standards of care and respect for all of our valued patients we ask some considerations in return. Please review our policies listed below and sign your agreement to these policies. Please also carefully review our Financial Policy attached; sign, date, and return to the office personnel.

Cancellation:

Please provide us with at least 24 hours notice of any need to cancel or re-schedule. This gives us the opportunity to offer an appointment to patients on our waiting list. Patients who provide us with less than 24 hours notice will be assessed a fee of $75.00 no show fee, out-of-pocket and not reimbursed by insurance.

Workers Comp / Motor Vehicle Accident:

Our office does not accept either Workers Comp or Motor Vehicle Accident claimants.

If there are any questions, please call (207) 798-3993, or email us at northernsunhealthcare@gmail.com .

Sincerely,
Vanessa Betancourt
Office Manager for Drs. Ackerly & Werner

Name: _____

Sign: _____ Date: _____

Financial Policy

Thank you for choosing Northern Sun Family Health Care & Birth Center. We are committed to building a successful collaborative relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to us. Please understand that payment for services is a part of that relationship, so please ask if you have any questions about our fees, our poliies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present an insurance card at your initial visit and updates for any changed. All co-payments are due at the time of your visit unless previous arrangements have been made with the Office Manager. We accept cash, checks, or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will submit your claim directly **for Maine Community Health Options or Cigna** policyholders as a courtesy. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If your insurance company is not contracted with us you are responsible for the full cost of our visit, we will provide a receipt and a claim form that you must submit directly to your insurance provider for reimbursement.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patients responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. All fees must be paid at the time of your visit.

Lab Testing

If you have insurance, we will submit your policy information on record to the lab for billing purposes. The billing for labs is directly between the patient and the lab performing the testing. For specific tests i.e. allergy testing through Alletess Laboratory, those are not paid by insurance and must be paid directly to the lab before they will process your lab request. Failure to do so will delay and may terminate the testing due to the viability of the blood sample. In this event, you would be required to pay for a new blood draw. It is our policy that Alletess lab reports will not be reviewed with, or copies provided to any patient with an outstanding balance for the testing.

Supplements/Herbs/Products

Full payment is required at time of receiving your supplements. If you are requesting products be mailed, you may contact our office with a debit or credit card for payment of your product(s) and the associated shipping fee. Once purchased any supplements, herbs, or products cannot be returned.

Returned Checks

The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account may be sent to the collection agency, or attorney, and possible discharge from the practice. In the even an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs, including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party

_____ _____

Signed Date

PERSONAL AND MEDICAL HISTORY

We know this form may take some time, but this information will allow us to provide you with the best possible care. We will go over this together at your visit. If you have any questions or don't understand something, please make a note and we can discuss it. ***This information will be kept completely confidential.***

Name: _____ Today's Date:_____

Date of Birth:_____ Age:_____ Sex:_____ Gender:_____

Preferred Pronouns:_____ Social Security Number:_____

Address:_____

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

E-Mail Address: _____

Occupation:_____ Education:_____ Religious/Spiritual Preference:_____

Married:_____ Partner:_____ Single:_____ Separated:_____ Divorced:_____ Widowed:_____

Spouse or Partner's Name:_____ Preferred Pronouns:_____

Date of Birth:_____ Age:_____ Sex:_____ Gender:_____

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

E-Mail Address: _____

Occupation:_____ Education:_____ Religious/Spiritual Preference:_____

Insurance Co.:_____ Policy #:_____ Group:_____

Address:_____

Children; Name/Age: _____

Emergency Contact Name:_____ Phone:_____

Address:_____

How did you hear about Northern Sun? _____

What are your most important health concerns? _____

Are you currently receiving health care? Y / N If so, with whom? _____

MEDICAL HISTORY/FAMILY HISTORY

	MOTHER	FATHER	SIBLINGS	SPOUSE	CHILDREN
Age (if living)	_____	_____	_____	_____	_____
Health (Good/Fair/Poor)	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____

Check all that are applicable:

	SELF	MOTHER	FATHER	SIBLINGS	SPOUSE	CHILDREN
Anemia						
Allergies						
Autoimmune condition						
Cancer						
Diabetes						
Epilepsy						
Glaucoma						
Heart disease						
High blood pressure						
Kidney disease						
Lyme disease						
Mental illness						
Obesity						
Thyroid disease						
Other						

HEALTH HISTORY

Weight: _____ Weight 1 year ago:_____ Maximum weight:_____

Height:_____ Any decrease in height? _____ Maximum height:_____

When during the day is your energy best? _____ Worst? _____

VACCINATION HISTORY

____ DTaP ____Polio/IPV ____HiB ____Hep B ____MMR ____Varicella ____Rotavirus ____Pneumococcus

____Flu ____H1N1 Flu ____Gardisil/HPV

Any adverse reactions to immunizations? (Please specify): Y / N

_____

HOSPITALIZATIONS AND SURGERIES

What hospitalizations and/or surgeries have you had? _____

_____

X-RAYS AND SPECIAL STUDIES

What x-rays, CAT scans, MRIs, Ultrasounds, or other studies have you had? _____

_____

ALLERGIES

Are you sensitive or allergic to any medications? _____

Any foods? _____

Please circle: Y = a condition you have now, N = never had, P = have had in the past

CHILDHOOD ILLNESSES

Chicken Pox	Y N P	German Measles	Y N P	Mumps	Y N P
Scarlet Fever	Y N P	Rheumatic Fever	Y N P	Whooping Cough	Y N P

CURRENT MEDICATIONS

Antacids	Y N P	Anti-anxiety medications	Y N P	Antibiotics	Y N P
Antidepressants	Y N P	Appetite suppressants	Y N P	Laxatives	Y N P
Pain medications	Y N P	Sleeping medications	Y N P	Thyroid Medication	Y N P

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are currently taking: _____

_____

DIET

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Coffee/caffeinated tea?	Y N P	Drink soda?	Y N P	Do you diet?	Y N P
Eat/crave sugar?	Y N P	Eat 3 meals a day?	Y N P	Eat out often?	Y N P

EMOTIONAL

Anxiety or nervousness	Y N P	Depression	Y N P	Mood swings	Y N P
Suicidal thoughts/attempt	Y N P	Tension	Y N P	Treated for problems?	Y N P

ENDOCRINE

Diabetes	Y N P	Excessive hunger	Y N P	Excessive thirst	Y N P
Fatigue	Y N P	Heat or cold intolerance	Y N P	Hypoglycemia	Y N P
Hypothyroid	Y N P	Seasonal depression	Y N P		

IMMUNE

Chemical sensitivity	Y N P	Chronic fatigue syndrome	Y N P	Chronic infections	Y N P
Chronic swollen glands	Y N P	Reactions to vaccinations	Y N P	Slow wound healing	Y N P

NEUROLOGIC

Easily stressed	Y N P	Loss of balance	Y N P	Loss of memory	Y N P
Muscle weakness	Y N P	Numbness or tingling	Y N P	Paralysis	Y N P
Seizures	Y N P	Vertigo or weakness	Y N P		

SKIN

Acne, boils	Y N P	Color change	Y N P	Eczema, hives	Y N P
Itching	Y N P	Lumps	Y N P	Night sweats	Y N P
Rashes	Y N P	Significant hair loss	Y N P		

HEAD

Headaches	Y N P	Head injury	Y N P	Jaw/TMJ problems	Y N P
Migranes	Y N P				

EYES

Blurry vision	Y N P	Cataracts	Y N P	Color blindness	Y N P
Double vision	Y N P	Eye pain/strain	Y N P	Glasses or contacts	Y N P
Glaucoma	Y N P	Impaired vision	Y N P	Spots in eyes	Y N P
Tearing or dryness	Y N P				

NOSE AND SINUSES

Frequent colds	Y N P	Hayfever	Y N P	Loss of smell	Y N P
Nose bleeds	Y N P	Sinus problems	Y N P	Stuffiness	Y N P

MOUTH, THROAT, AND NECK

Copious saliva	Y N P	Dental cavities	Y N P	Frequent sore throats	Y N P
Goiter	Y N P	Gum disease	Y N P	Hoarseness	Y N P
Jaw clicks	Y N P	Lumps	Y N P	Pain or stiffness	Y N P
Sore tongue/lips	Y N P	Swollen glands	Y N P	Teeth grinding	Y N P

RESPIRATORY

Asthma	Y N P	Bronchitis	Y N P	Cough	Y N P
Fainting	Y N P	Emphysema	Y N P	Pain on breathing	Y N P
Low blood pressure	Y N P	Pneumonia	Y N P	Shortness of breath	Y N P
Phlebitis	Y N P	Sputum production	Y N P	Wheezing	Y N P

CARDIOVASCULAR

Angina	Y N P	Blood clots	Y N P	Chest pain	Y N P
Fainting	Y N P	Heart disease	Y N P	High blood pressure	Y N P
Pleurisy	Y N P	Murmurs	Y N P	Palpitations/fluttering	Y N P
Spitting up blood	Y N P	Rheumatic fevers	Y N P	Swelling in ankles	Y N P

GASTROINTESTINAL

Belching or passing gas	Y N P	Blood in stool	Y N P	How many bowel movements per day?	
Change in appetite	Y N P	Change in stools	Y N P	Change in thirst	Y N P
Constipation	Y N P	Diarrhea	Y N P	Gall bladder disease	Y N P
Heartburn	Y N P	Hemorrhoids	Y N P	Jaundice (yellow skin)	Y N P
Liver disease	Y N P	Nausea	Y N P	Pain or cramps	Y N P
Tarry/black stools	Y N P	Trouble swallowing	Y N P	Ulcer	Y N P
Vomiting	Y N P	Vomiting	Y N P		

URINARY

Frequency at night	Y N P	Frequent infections	Y N P	Inability to hold urine	Y N P
Increased frequency	Y N P	Kidney stones	Y N P	Pain on urination	Y N P

SEXUAL HISTORY

Are you sexually active?	Y N P	Orientation? _____		Chlamydia	Y N P
Gonorrhea	Y N P	Hepatitis A / B / C	Y N P	Herpes I / II	Y N P
History of abuse	Y N P	HIV	Y N P	HPV (Genital warts)	Y N P
Pain during intercourse	Y N P	Sexual Difficulties	Y N P	Syphilis	Y N P

MALE REPRODUCTION

Birth control type:_____				Discharge or sores	Y N P
Hernias	Y N P	Impotence	Y N P	Premature ejaculation	Y N P
Prostate disease	Y N P	Testicular masses	Y N P	Testicular pain	Y N P

FEMALE REPRODUCTION

Menstrual Cycle

Age at first period? _____		Abnormal PAP	Y N P	Are/were cycles regular?	Y N P
Bleeding between cycles	Y N P	Endometriosis	Y N P	Gardnerella infections	Y N P
Heavy / Excessive / Clots (circle one)		Length of cycle: _____		Ovarian cysts	Y N P
Painful menses	Y N P	Pelvic inflamm. disease	Y N P	Yeast infections	Y N P
PMS	Y N P	If yes, what are your symptoms? _____			

Reproductive History

Number of pregnancies:_____		Number of abortions:_____		Number of births:_____	
Number of miscarriages:_____		Difficulty conceiving	Y N P	Birth control	Y N P

Birth control type / duration / satisfaction:_____

Children's names & ages:_____

Menopause

Age of menopause:_____		Hormone therapy	Y N P	Hot flashes	Y N P
Loss of libido	Y N P	Mood swings	Y N P	Vaginal dryness	Y N P

Breast

Breast implants	Y N P	Breast lumps	Y N P	Breast pain/tenderness	Y N P
Breast redness	Y N P	Mammograms	Y N P	Nipple discharge	Y N P
Do you do self breast examinations?			Y N P		

BLOOD/PERIPHERAL VASCULAR

Anemia	Y N P	Cold hands/feet	Y N P	Deep leg pain	Y N P
Easy bleeding/bruising	Y N P	Thrombophlebitis (clots)	Y N P	Varicose veins	Y N P

MUSCULOSKELETAL

Arthritis	Y N P	Broken bones	Y N P	Joint pain or stiffness	Y N P
Muscle spasms or cramps	Y N P	Sciatica	Y N P	Weakness	Y N P

HABITS

Do you use alcohol?	Y N P	Number of drinks a week:_____		Treatment for addiction?	Y N P
Recreational drugs?	Y N P	Type and frequency:_____			
Tobacco?	Y N P	Number of packs per day:_____			

SLEEP

Difficulty falling asleep	Y N P	Difficulty getting back to sleep	Y N P	Nap	Y N P
Sleep 7-8 hours per night	Y N P	Wake often	Y N P	Wake rested	Y N P

EXERCISE/ACTIVITES

What type of exercise/activities do you enjoy the most? _____

What are your current exercise habits/patterns? _____

PERSONAL/SOCIAL

Do you have a spiritual or religious practice?	Y N P	Do you have a community of support?	Y N P
Do you have a supportive relationship?	Y N P	Any history of trauma or abuse?	Y N P

How does your condition affect you? _____

_____

What do you think is happening and why? _____

_____

What do you enjoy most about your life? _____

_____

How much change are you willing to make at this time to improve your health? (circle your choice below)

MINIMAL SOME COMPLETE

We look forward to partnering with you in your quest for optimal health and well being.

If you have any questions, please feel free to ask! Welcome!