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

Hello

We are delighted you are considering having a birth center or home birth. At your consultation visit, we will be exploring what it means to give birth at our birth center or your home. Please bring any questions you have concerning your pregnancy and birth to discuss at this visit. We feel it is very important for both partners to be present at this interview, so please make every effort to schedule an appointment you both can attend.

After a consultation most parents like to go home and think things over before they make a decision about their place of birth and care providers. If you are certain that you would like to have us as your midwives, we can make an appointment for you right away for your next visit. If you need to discuss your options with your partner, we encourage you to do so before calling back to make your next appointment.

An important element of midwifery care is establishment of a warm and open relationship. We look forward to meeting you and your partner or spouse.

Sincerely,

Sarah Ackerly, ND, CMP
Carrie Werner, ND, CPM

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:____

How did you hear about Northern Sun? ______________________________

Please tell us your thoughts or feelings on why you want to have your baby at ___ home or at ____ The Birth Center?

Mother:____

____

____

____

____

Partner/Spouse:____

____

____

____

____

Have either of you seen a baby being born? ______________________________

Mother's Family History – check if anyone in your immediate family (grandparents, parents & siblings) has ever had these conditions.

_______ Cancer	_______ Heart disease	_______ High blood pressure
_______ Diabetes	_______ Epilepsy	_______ Blood clotting problems
_______ Alcohol/drug problems	_______ Severe emotional problems	_______ Tuberculosis
_______ Twins, triplets	_______ Allergies	_______ Varicose veins
_______ Hepatitis/jaundice	_______ Birth defects/congenital anomalies	

Were your mother's labors long, average or short (circle one)? Any difficulties? ________________________________

Your sister's labors? ____

How much did you weigh at birth? __________________________________ Were you breastfed? __________________

Did your mother take DES (diethylstibestrol) when she was pregnant with you? _________________________________

Father's Family History - Check if any of these ever happened to you or anyone in your family:

_______ Heart disease	_______ High blood pressure	_______ Tuberculosis
_______ Diabetes	_______ Hepatitis/jaundice	_______ Birth defects/congenital anomalies

Mother's Medical History – Please check if you ever had any of these:

_______Hospitalizations	_______ Accidents	_______ Childhood diseases
_______ Rheumatic fever	_______ Thyroid problems	_______ Cancer
_______ Mononucleosis	_______ Eye or vision problems	_______Ear or hearing problems
_______ Hemorrhage	_______ Varicose veins or phlebitis	_______ Tuberculosis
_______ Stomach problems	_______ Bowel problems	_______ Liver problems
_______Aching joints	_______ Seizures, epilepsy	_______ Jaundice
_______ Breast biopsy or lumps	_______Hernia	_______ Blood clotting problems
_______ Major illnesses	_______ Surgeries	_______ Blood transfusions
_______ Diabetes	_______ Urinary tract infections	_______ Kidney or bladder infections
_______ Hepatitis/jaundice	_______ Severe headaches	_______ Dental problems
_______ Anemia	_______ High blood pressure	_______ Hemorrhoids
_______ Asthma	_______ Water retention	_______ Gall bladder problems
_______ Hypoglycemia	_______ Pelvic or back injuries	_______ Emotional problems
_______ Skin problems	_______ Appendicitis	_______ Scoliosis
_______ Blood in stool	_______ Food or other allergies	_______ Allergies to medications
_______ Lyme disease	_______ MRSA (staph infection)	_______ Other

How would you describe your overall health? ____

How would you describe your diet? ____

Do you get any form of regular exercise? ____

What is your usual non-pregnant weight? _________________________________ Height? ______________________

Do you have a high, moderate or low stress life? ____

Have you ever experienced large changes in your weight in one year? ___________________________________

Have you ever had anorexia, bulimia, or any eating problems? _______________________________________

Do you bruise easily? _____________________ Do you regularly use antacids or laxatives? ______________________

Gynecologic History

Age at 1st period ______ How many days apart is your menstrual cycle ______ Regular / Irregular (circle one)

Do you have menstrual cramps? ______ How many days do you bleed? ______ Heavy / Medium / Light (circle one)

Do you bleed between periods? ______ Do you have PMS symptoms? ____

Please check if you have ever had the following:

______ Infertility
______ Cervicitis
______ Cervical surgery
______ Cervical polyp
______ Ovarian cyst
______ Fibroids
______ Endometriosis
______ Abnormal bleeding
______ Uterine surgery
______ Breast lumps
______ Breast surgery
______ Yeast infection
______ Trichomonas
______ Chlamydia
______ Gardnerella
______ Herpes (___oral ___ genital)
______ Gonorrhea
______ Syphilis
______ Pelvic inflammatory disease
______ Genital warts
______ Genital sores
______ Other

Has the father of the baby ever had:

______ Herpes (___oral ___ genital)
______ STIs
______ Tobacco use
______ Blood transfusions
______ Urethritis
______ Alcohol or drug use
______ Severe emotional problems
______ Hepatitis/jaundice

When was your last pap smear? __________ Have you ever had an abnormal pap? __________

Do you do monthly breast exams? __________

Have you had more than three sexual partners in the last five years? __________

Have you ever used drugs intravenously? __________

Have you ever had a sexual partner who used drugs intravenously or had a blood transfusion? ______________________

Are you now or have you ever been abused, whether emotionally intimidated or physically beaten, injured or made to take part in sexual activities against your will? ____

Is there anything about the development of your sexuality that you would like to discuss? __________________________

Please list the methods of contraception that you have used, and whether you liked it or not. Put a star next to the most recent method used.

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____

____

Obstetric History:

Please describe below each time you have been pregnant, including miscarriages, and abortions starting with the first pregnancy.

	Name	Birthday	Due Date	Length of labor	Where	Wt Gain	Infant Wt	Complications
1.								
2.								
3.								
4.								
5.								
6.								

Present Pregnancy:

Date of your last menstrual period? ________________________ Is this sure or an estimation? _______________________

Was the amount and length of bleeding in that period normal for you? ____

If not, when was your previous period? _____________________ Do you know the date you conceived? ______________

Is this a planned, an "okay if it happens," or an unplanned pregnancy? ____

How are you feeling about this pregnancy? ____

Did you have a positive pregnancy test (either lab or home)? ___________________________ Date: _________________

Are you and the father of this baby related by blood (for example: cousins)? _____________________________________

Have you breastfed any of your previous babies? ___________________________ Any problems? __________________

____

Please check if you've had any of the following problems during this pregnancy:

______ Nausea
______ Headache
______ Hemorrhoids
______ Constipation
______ Visual problems
______ Vaginal discharge
______ Rash
______ Family/relationship problems
______ Other
______ Vomiting
______ Dizziness/fainting
______ Backache
______ Diarrhea
______ Urinary complaints
______ Indigestion
______ Loneliness
______ Work problems
______ Fever
______ Varicose veins
______ Swelling/edema
______ Unusual fatigue
______ Abdominal/pelvic pain
______ Leg cramps
______ Depression
______ Sleeping problems

Please indicate if you have used or have been exposed to the following in this pregnancy:

______ Tobacco smoke
______ Caffeine
______ Prescription medications
______ Fumes/sprays
______ Hot tub or sauna
______ Other
______ Occupational exposure
______ Recreational drugs
______ Herbal medications
______ X-rays
______ Vaccinations
______ Alcohol
______Over-the-counter medications
______ Vitamins
______ Infections diseases
______ Cat feces/bird droppings

Are there any particular ethnic, cultural, religious, or personal preferences for your care that you would like us to know about? ____

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Please use this space for any other information that you'd like to discuss or that is important to you or your partner/spouse: ____

____

____

Mother's signature: ____ Date: ______________________

Partner/spouse's signature: ____ Date: ______________________