NORTHERN SUN
FAMILY HEALTH CARE

SARAH ACKERLY, N.D., CPM **ALICIA THOMAS, N.D.**

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. Thomas 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 office personnel.

Cancellation:

Please provide us with at least 24 hours notice of any need to cancel or reschedule. 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, 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 H. Betancourt
Office Manager

Name Printed: _____

Signature: _____

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 policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc). A missed appointment fee of $75 will be assessed when 24 hour notice is not provided to office prior to scheduled appointment.

Co-pays
The patient is expected to present an insurance card at your initial visit and updates for any changes. All co-payments are due at time of your visit unless previous arrangements have been made with the Office Manager. We accept cash, check 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** policy holders 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 your visit, we will provide a receipt and a claim form that you may 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 patient's 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 covered 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 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. ***We have a no return policy (even if unopened) for all supplements, no exchanges or credits will be provided.***

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 event 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. A finance charge may be applied.

_____ _____
Signed Date

_____
Printed

NORTHERN SUN
FAMILY HEALTH CARE

TEEN INTAKE

Name_____ Preferred Name_____ Today's Date_____

Age_____ Date of Birth_____ Sex: _____SS# _____

Address_____

City_____ State_____ Zip_____

Telephone H: _____ Parent Cell:_____ Cell: _____

Mother/Guardian_____ Date of Birth_____

Occupation_____ Employer: _____

Father/Guardian_____Date of Birth_____

Occupation_____ Employer: _____

E-Mail Address_____ E-Mail Address_____

Emergency contact Name_____

Phone # _____ Address _____

How did you hear about Northern Sun?_____

What are your most important health concerns?_____

Are you currently receiving healthcare? Y N If so, with whom? _____

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? _____

MEDICATIONS

	Now	Past		Now	Past		Now	Past
Antidepressants	___	___	Antibiotics	___	___	Decongestants	___	___
Anti-anxiety Meds	___	___	Antihistamines	___	___	Steroids	___	___
Inhalers	___	___	Asthma Meds	___	___	Acne Meds	___	___
Pain Relievers	___	___	Sleep Meds	___	___			

Allergies to Medications_____

MEDICAL HISTORY

___ Chicken Pox ___ Headaches ___ Bronchitis ___ Tonsillitis, # of times ___

___ Measles ___ Pneumonia ___ Lyme disease ___ Ear Infections, # of times ___

___ Diabetes ___ Frequent Colds ___ Eczema ___ Asthma

___ Depression ___ Insomnia ___ Other _____

VACCINATION HISTORY

____ DTaP ____ Polio/IPV ____ HiB ____ Hep B ____ MMR ____ Varicella ____ Rotavirus ____ Pneumococcus

____ Flu ____ H1N1Flu ____ Gardisil/HPV_____ Any adverse reactions to immunizations? (Please specify): Y/ N

_____

X-RAYS, SPECIAL STUDIES, INJURIES, HOSPITALIZATIONS AND SURGERIES

When Where Results

_____

FAMILY HISTORY

___ Heart Disease ___ Diabetes ___ Birth Defects ___ Cancer ___ Mental Illness

___ Hypertension ___ Arthritis ___ Tuberculosis ___ Allergies ___ Hay Fever

___ Eczema ___ Psoriasis ___ Lyme disease ___ Autoimmune disease

SYMPTOMS

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

Hives	Y N P	Headaches	Y N P	Depression	Y N P
Eczema	Y N P	Frequent Urination	Y N P	Anxiety	Y N P
Bleeding gums	Y N P	Heart Murmur	Y N P	Nervous	Y N P
Nose Bleeds	Y N P	Vomiting Spells	Y N P	Sleep Problems	Y N P
Acne	Y N P	Anemia	Y N P	Night Sweats	Y N P
High Fevers	Y N P	Stomach Aches	Y N P	Sensitive to light	Y N P
Chronic Rashes	Y N P	Jaundice	Y N P	Body/Breath Odor	Y N P
Hearing Loss	Y N P	Easy Bruising	Y N P	Motion/car sickness	Y N P
Diarrhea	Y N P	UTI	Y N P	No Appetite	Y N P
Sore Throats	Y N P	Constipation	Y N P	Nightmares	Y N P
Dizziness	Y N P	Gas	Y N P	Canker Sores	Y N P
Frequent Colds	Y N P	Bleeding Tendency	Y N P	Unusual Fears	Y N P
Wheezing	Y N P	Joint Pains	Y N P	Excessive Fatigue	Y N P
Cough	Y N P	Respiratory Problems	Y N P	Hair Loss	Y N P

Any other condition not mentioned?_____

DIET

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Food Allergies/Intolerances_____

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

HABITS

Alcohol or drug use?	Y N P	Treatment for addiction?	Y N P
Recreational drugs?	Y N P	Type and Frequency _____	
Tobacco?	Y N P	Amount and Frequency_____	
Screen Time?	Y N P	# Hours/day _____	
Use of seatbelt?	Y N P		

FEMALE REPRODUCTION

Age of 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	Y N P	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 _____

MALE REPRODUCTION

Birth control type_____				Discharge or sores	Y N P
Hernias	Y N P	Testicular masses	Y N P	Testicular pain	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

SLEEP

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

EXERCISE/ACTIVITIES

What types 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 supportive relationships?	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 feel needs to happen for you to get better? _____

_____

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 to Northern Sun Family Health Care ~