



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 the office personnel.

Cancellation:

We ask that you 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 may have a \$75.00 no show fee applied to their account unless the appointment time can be filled.

This fee will be out-of-pocket and not reimbursed by insurance.

Please let the office staff know of any extenuating circumstances that are a factor for any last minute cancellation notifications.

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](mailto:northernsunhealthcare@gmail.com) .

Sincerely,  
Allie Latterell  
Office Manager

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 policies, 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 changes. 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 Anthem, Community Health Options, and Cigna** policyholders as a courtesy. If you are an Anthem policy holder, it is Northern Sun's policy that a referral is required and received by our office in order to schedule a new patient appointment. If your policy does not require a referral, please request a letter or document noting that a referral will not be required for coverage of specialist services. 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

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Signed

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Date

## PEDIATRIC INTAKE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Gender: \_\_\_\_\_ SSC#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Alternate #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Mother or Guardian: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours a week: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Married: \_\_\_\_\_ Partner: \_\_\_\_\_ Single: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

Father or Guardian: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours a week: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Married: \_\_\_\_\_ Partner: \_\_\_\_\_ Single: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

How did you hear about Northern Sun? \_\_\_\_\_

What are your child's most important health concerns? \_\_\_\_\_

Is your child currently receiving healthcare? Y / N If so, with whom? \_\_\_\_\_

**Please circle: Y = a condition your child has now, N = never had, P = has had in the past**

### MEDICATIONS

Antibiotics	Y N P	Anti-histamines	Y N P	Aspirin	Y N P
Asthma medications	Y N P	Decongestants	Y N P	Ibuprofen	Y N P
Inhalers	Y N P	Topical steroids	Y N P	Tylenol	Y N P
Other: _____		Allergies to medications? _____			

### MEDICAL HISTORY

Allergies	Y N P	Asthma	Y N P	Bronchitis	Y N P
Chicken pox	Y N P	Croup	Y N P	Ear infections	Y N P
Eczema	Y N P	Frequent colds	Y N P	Lyme disease	Y N P
Pneumonia	Y N P	Scarlet Fever	Y N P	Tonsillitis	Y N P

Other: \_\_\_\_\_

### X-RAYS, SPECIAL STUDIES, INJURIES, SURGERIES OR HOSPITALIZATIONS

When	Where	Results

### VACCINATION HISTORY

DTaP    Polio/IPV    HiB    Hep B    MMR    Varicella    Rotavirus    Pneumococcus  
 Flu    H1N1 Flu    Gardasil/HPV

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

### FAMILY HISTORY

Allergies	Y N P	Arthritis	Y N P	Birth defects	Y N P
Cancer	Y N P	Diabetes	Y N P	Eczema	Y N P
Hay fever	Y N P	Heart disease	Y N P	Hypertension	Y N P
Mental illness	Y N P	Psoriasis	Y N P	Tuberculosis	Y N P
Other: _____				Sexually transmitted disease	Y N P

### BIRTH HISTORY

Mother's age at birth: _____		Mother's health during pregnancy: _____			
Bleeding	Y N P	Cigarettes/alcohol/drugs	Y N P	Diabetes	Y N P
Hypertension	Y N P	Illness	Y N P	Nausea	Y N P
Physical/emotional trauma during pregnancy			Y N P	Thyroid problems	Y N P
Term (circle one): Full / Premature / Late			Weight at birth: _____		
APGAR score: _____		Length of labor: _____			
Complications: _____					
As a baby, did your child have any of the following problems?					
Allergies	Y N P	Birth defects	Y N P	Birth injuries	Y N P
Blue baby	Y N P	Cerebral palsy	Y N P	Colic	Y N P
Diarrhea	Y N P	Fever	Y N P	Jaundice	Y N P
Rashes	Y N P	Seizures	Y N P	Other: _____	
Feeding (circle one): Breast fed / Milk-based formula / soy formula				How long? _____	
Age began: Solid foods: _____		Sitting: _____		Crawling: _____	
		Walking: _____		First words: _____	
Child's sleep patterns first year: _____					
Current weight: _____		Current height: _____		Any concerns about your child's growth? _____	

### SYMPTOMS

Acne	Y N P	Anemia	Y N P	Bleeding gums	Y N P
Bleeding tendency	Y N P	Bloody urine	Y N P	Body/breath odor	Y N P
Burning of urine	Y N P	Canker sores	Y N P	Chronic rash	Y N P
Constipation	Y N P	Cough	Y N P	Cries easily	Y N P
Diarrhea	Y N P	Dizzy spells	Y N P	Easy bruising	Y N P
Eczema	Y N P	Excessive fatigue	Y N P	Flat feet	Y N P
Frequent colds	Y N P	Frequent urination	Y N P	Gas	Y N P

Hair loss	Y N P	Headaches	Y N P	Hearing loss	Y N P
Heart murmur	Y N P	High fevers	Y N P	Hives	Y N P
Jaundice	Y N P	Joint pains	Y N P	Motion/car sickness	Y N P
Nervous	Y N P	Nightmares	Y N P	Night sweats	Y N P
No appetite	Y N P	Nose bleeds	Y N P	Sensitive to light	Y N P
Sleep problems	Y N P	Sore throats	Y N P	Stomach aches	Y N P
Unusual fears	Y N P	Vomiting spells	Y N P	Wheezing	Y N P
Any other condition not mentioned? _____					

### DIET

Please describe your child's typical diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Food allergies (if known): \_\_\_\_\_