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 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.

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 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 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 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

Signature: ______________________________ Date: ______________

Section 1: Registration Information

Name:			Date:
How do you prefer to be addressed?:			
Address:			
City:	State:		Postal Code:
Cell/Home phone:	Work phone:		
E-mail:			Preferred Pronouns:
Date of Birth:	Age:		Gender: □ Male; □ Female; □ ______
Occupation:		Hrs per Week:	
Emergency Contact:		Phone:	
Please Check One: □ Married/ □ Partnership/ □ Separated/ □ Divorced/ □ Widowed/ □ Single			
How did you hear about Dr. Alicia Thomas, ND?			
What time of day do you prefer: □ Mornings / □ Afternoon / □ Evenings / □ No Preference			
Can we add you to our e-Newsletter list to receive current information on the clinic & promotions □ Yes/ □ No			

Section 2: Health Overview

What are your health concerns, in order of importance to you?:

1)______________________ 2)______________________

3)______________________ 4)______________________

5)______________________ 6)______________________

Is this your first visit to a Naturopathic Doctor? □ Yes/ □ No If No, please specify:______________________
Religious affiliations and beliefs relevant to health care and treatment:______________________

- **Other Health Care Providers**

Name of current Family Physician:______________________ Phone:______________________
Family Physician's Fax:______________________
When was your last visit to your Family Physician?:______________________
When was your last physical exam?:______________________
Are you seeing a medical specialist?: □ Yes/ □ No If Yes, for what reason?:______________________
If yes, Name of medical specialist:______________________
Other health care providers:______________________
Other health care providers contact information:______________________

- **Current Medications & Supplements**

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics etc.). If possible, also list dosage information and how long you have been taking the medication as well as the brand.

Medication/ Supplement	Dosage/Brand

Medication/ Supplement	Dosage/Brand

- **Allergies**

Please list all known allergies (medications, environmental, chemical, food etc.):

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Section 3: Health History

Height__________Weight__________Weight 1 year ago________Maximum weight________When?__________

Have you □ gained/ □ lost any weight lately? If so, please state how much:_______________________
In what areas have you gained the most weight?: □ Breasts □ Hips □ Midsection □ Thighs □ Back □ Arms

When during the day is your energy and alertness best?__________________Worst?______________

Please rank on a scale of 1 to 10, 10 being the WORST
Work/School Stress ________________
Home Stress ____________________
Emotional Stress _________________
Relationship Stress_________________
Quality of Sleep __________________
Memory ______________________
Regular exercise: □ Yes □ No Type:_________________ Duration:___________ □ 1-2d/wk □ 3-4d/wk □ 5-7d/wk

Average hours of sleep per night?______________Do you wake feeling rested? □ Yes/ □ No/ □ Sometimes
Any trouble: □ falling asleep?/ □ staying asleep?/ □ wake often?/ □ wake early?/ □ difficulty waking?

Do you have regular bowel movements? □ Yes/ □ No Are they painful to pass? □ Yes/ □ No
Do you experience Gas □ Yes/ □ No - Bloating □ Yes/ □ No - Indigestion □ Yes/ □ No – Acid reflux □ Yes/ □ No
What is the colour of your stool? ___________________ Is it well formed? □ Yes/ □ No
Is there ever blood in your stool? □ Yes/ □ No Mucous? □ Yes/ □ No Undigested foods? □ Yes/ □ No

Menses: How many days is the cycle (i.e. 28 days) _________ Is the menstrual cycle regular? □ Yes/ □ No
PMS symptoms? □ Yes/ □ No – Bloating □ Yes/ □ No – Headaches □ Yes/ □ No – Cramps □ Yes/ □ No
When was your last PAP: __________________ Mammogram: ____________Menopause Age:_______

Do you use any of the following?:

Substance	Form/ Type	Amount per day/ week/ or month (please specify)
Alcohol		
Tobacco (cigarettes)		
Recreational drugs		
Coffee – ingredients added to it		
Tea – ingredients added to it?		
Carbonated beverages		
Laxatives		
Diet pills/ Appetite suppressants		
Antacids		
Pain relievers		
Birth Control Pill		
Fast food		
Water		

- **Hospitalizations, Surgeries, Imaging**

Do you get regular screening tests done by another doctor (Pap, Blood tests, etc?) □ Yes □ No
Please list any hospitalizations, surgeries, X-rays, and other imaging scans that you have had:
________________________Year:________ ________________________Year:____________________
________________________Year:________ ________________________Year:____________________
________________________Year:________ ________________________Year:____________________
________________________Year:________ ________________________Year:____________________

Thank you for taking the time to complete this extensive intake form.

Please return this form to the office **prior to your first visit**
so that she can evaluate and assess the given information and provide you with well researched treatment options and recommendations.