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: _____

53 MAIN ST, TOPSHAM, ME 04086 TEL: (207) 798-3993 FAX: (207) 798-3999

# 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 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

_____ _____

Signed 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 ____Gardisil/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):_____