WHITE SPRUCE MEDICAL

100 Chushman St. Ste 309
Fairbanks, Alaska 99701

PATIENT INFORMATION

Please Print

Patients Name | Date of Birth | Sex | Social Security #

Mailing Address | City | State | Zip Code

Physical Address

Home Phone | Work Phone/ext. | Cell Phone | E-mail Address

Preferred Contact Number (Cell, Home, or Work) | ☐ Check Box to ***Not*** Receive Email Updates

Emergency Contact | Relationship | Home Phone | Work Phone/ext.

Employer (If self-employed, name of business) | Union Local No. | Work Phone/ext.

Whom may we thank for referring you to us?_____ How did you hear about us? _____

SPOUSE/GUARDIAN INFORMATION

Name | Date of Birth | Sex | Social Security #

Employer (If self-employed, name of business) | Union Local No. | Work Phone/ext.

INSURANCE & BILLING INFORMATION

Complete for each Primary Secondary Tertiary Other Insurance

Insurance Company

Policy Holder's Name and Date of Birth (Required for billing insurance)

Relationship to Patient

AUTHORIZATION: I understand full payment for treatment received is my responsibility regardless of my insurance coverage. I hereby authorize White Spruce Medical to release to my insurance company any information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to White Spruce Medical any benefits due me that have not been paid.

Signature | Date

Internal Use Only:

Meditouch:_____ Amazing Charts:_____ By_____

WHITE SPRUCE MEDICAL

Financial Policy

At **White Spruce Medical,** we are committed to providing you the best possible care. If you have medical insurance we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will process and submit your claim for reimbursement. If your insurance plan indicates they may cover our services, you will be required to pay any estimated deductible, co-pay and/or percentage as stated by your insurance company at the time of service and are payable by credit card, cash, or check. ***Be aware that some insurance companies including Medicare and Medicare supplemental insurance do not cover medical care rendered by alternative providers.*** You are responsible for all balances unpaid by your insurance company.

All supplements, tinctures, etc. are to be paid for when received. Supplements are not covered by insurance.

Your insurance in a contract between you, your employer, and the insurance company. **White Spruce Medical is not a party of that contract.**

We verify insurance coverage and information as needed, but not all services are a covered benefit in all contracts. ***Insurance companies do not guarantee coverage.*** Any misinformation we may relay to patients from their insurance companies is not the responsibility of **White Spruce Medical**. We will have no way of knowing how your insurance policy is written. All are different.

We cannot become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary.

If you receive an insurance check in payment for services rendered at White Spruce Medical, it is your responsibility to notify us and apply the full amount to the appropriate date of service. Upon your receipt of payment from the insurance company, the balance due on that date of service becomes due for immediate payment.

We will file secondary insurance claims as a courtesy. These claims cannot be filed until the primary insurance company has responded. If payment is not received form the secondary carrier within 30 days from filing, these charges are due and payable by you immediately.

White Spruce Medical will honor all in network contracts we have with insurance companies. Currently **White Spruce Medical is in network with PREMERA BLUE CROSS BLE SHIELD at this time.**

As a patient, you are ultimately responsible to pay for all services rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise contact our office promptly for assistance in the management of you account.

If you have any questions regarding this policy or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read the above financial policy and understand and agree to abide by the provisions and requirement therein.

_____ _____

Patient or Guardian Signature Date

_____ _____

Front Desk Personnel Signature Date

WHITE SPRUCE MEDICAL

Past Medical History

Patient Name: _____ Date of Birth: _____

Chief Concern or Goal for Visit: _____

Allergies (medications, food, etc): _____

_____

Current Medications: _____

_____

Current Supplements: _____

_____

Proir Illnesses and Injuries: ☐ None of these ☐ Other: _____

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Seizures ☐ Thyroid Disease
☐ Hepatitis ☐ High Blood Pressure ☐ Rheumatic Fever ☐ Stroke

Current Immunizations: ☐ Yes ☐ No

☐ Surgeries: _____

☐ Significant Trauma (car accident, stress, etc): _____

☐ Hospitalizations (list dates): _____

Family History: ☐ None of these ☐ Other: _____

☐ Diabetes ☐ Heart Disease ☐ Stroke
☐ Alchoholism ☐ High Blood Pressure ☐ Asthma

☐ Cancer (Please Specify): _____

Social History:
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Number of Children (if any): _____

Number of People in the Household: _____
Current Occupation: _____ Previous Occupation: _____

Habits (Please Specify Amouts):

Alcohol _____ Caffeine _____ CBD / THC _____ Soda _____ Tobacco _____

Exercise (Please Describe Type and Frequency): _____

_____

WHITE SPRUCE MEDICAL Past Medical History

Please check all that appy

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ General Sleep Problems
- ☐ Night Sweats
- ☐ Unexplained Weight Gain/Loss
- ☐ **None of these**

Eyes
- ☐ Cataracts
- ☐ Dizziness
- ☐ Sinus Problems
- ☐ Glasses/Contacts
- ☐ Night Blindness
- ☐ Spots in Eyes
- ☐ Vision Changes
- ☐ **None of these**

Head and Neck
- ☐ Dry Mouth or Throat
- ☐ Ear Aches
- ☐ Excessive Mucous
- ☐ Gum/Teeth Problems
- ☐ Headaches
- ☐ Mouth Sores
- ☐ Nose Bleeds
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Sinus Problems
- ☐ **None of these**

Cardiovascular
- ☐ Blood Clots
- ☐ Chest Pain
- ☐ Cold Hands/Feet
- ☐ Fainting
- ☐ Irregular Heartbeats
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Swelling Hand/Feet
- ☐ **None of these**

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Excessive Phlegm
- ☐ Pneumonia
- ☐ **None of these**

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Bloody Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Gas or bloating
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ **None of these**

Bowel Movements

Frequency: _____

Genitourinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Pain w/ Urination
- ☐ STI / STD
- ☐ Impotency
- ☐ Genital Discharge
- ☐ Genital Sores
- ☐ Irregular Periods
- ☐ Intermenstrual Spotting
- ☐ Menstrual Cramping
- ☐ **None of these**

Integumentary
- ☐ Acne
- ☐ Eczema
- ☐ Hair Changes/Problems
- ☐ Hives
- ☐ Rashes
- ☐ Skin Changes
- ☐ **None of these**

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain or Arthritis
- ☐ Loss of Height
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ **None of these**

Neurological
- ☐ Areas of Numbness
- ☐ Concussion
- ☐ Migraines
- ☐ Poor Memory
- ☐ Seizures
- ☐ **None of these**

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Easily Stressed
- ☐ Suicidal Thoughts or Attempts
- ☐ **None of these**

Endocrine
- ☐ Hot or Cold Intolerance
- ☐ Increased Hunger
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ **None of these**

Hematologic/Lymphatic
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Lymph Nodes
- ☐ **None of these**

Female Reproductive

Last Period _____ (Date)

Pregnancies _____

Births _____

Miscarriges _____

Birth Control Yes / No _____ (Specify Type)

Menopause Yes / No _____(Date)

Last PAP Smear _____ (Date)

Last Mamogram _____ (Date)

Please describe any other symploms you are experiencing not listed above:

_____

_____

_____

WHITESPRUCEMEDICAL

Notice of Privacy Policy
Right to Notice

White Spruce Medical may use your protected health information for treatment, payment, and health care operations. White Spruce Medical is the sole holder of your healthcare information. We will not release your information to any healthcare providers outside of our clinic without your written consent.

We will only disclose health information to a family member, or another person responsible for your care, with a written and signed directive.

We will not use your health information for marketing communication without your written consent.

White Spruce Medical will never give your demographics, personal information, or medical records to any medical provider who has left the practice. It is unlawful.

Most uses and disclosures that do not fall under treatment, payment or healthcare operations will require your written consent. Upon signing any consent form you may revoke your authorization in writing through our practice at anytime.

Initial _____

Specialty Claims

Workman's Compensation/Auto Accident – Your specialty claim information must be provided to us prior to your first visit. We must receive authorization that your claim is "active" and they will pay your claims, before services are rendered. We will file your specialty claims after each visit.

Medicare – Medicare does not cover or pay for services rendered by a naturopathic doctor.

Medicaid – Medicaid will not cover any services rendered at White Spruce Medical

For all the above, the patient is ultimately responsible for payment.

Initial _____

Missed Appointment Policy

Patients are responsible to attend all scheduled appointments. In the event the patient cannot make an appointment he or she is required to give at least 24 hours notice. For every same day cancellation or missed appointment, we reserve the right to charge the patient or responsible party $50 per appointment. At the White Spruce Medical we understand unique situations arise where missing a scheduled appointment is unavoidable and if such a situation occurs, we will be happy to work with you on a case by case basis.

Initial _____