White Pine Holistic Medicine
Sally D. Haley, M.D.
93 Church Road, Brunswick, ME 04011
Phone: (207) 798-5907 - Fax: (207) 729-5757
http://www.sallyhaleymd.com

Patient Information

Date: _____
Name: _____
Date of birth: _____ Social Security #: _____
Address: _____
City, State, Zip: _____
Mailing address (if different): _____
Home ✆: _____ Work ✆: _____ Cell/Pager/Other: _____
Please circle a phone number where we may leave confidential information, if we are not able to reach you in person.
If you do not have a confidential number, please check here: ☐
Email address: _____
Occupation: _____ Employer: _____
Employer address: _____
Employer phone: _____
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ Widowed ☐ Minor (under 18)
Emergency contact name, relationship: _____
Emergency contact phone: _____
Whom may we thank for referring you? _____

Health Care Provider(s)

Primary care provider: _____ Phone: _____
Specialist(s) you see: _____ _____
_____ _____
_____ _____

Insurance Information

Name of Insurance company: _____
Address: _____
Insured / Guarantor: ☐ Male / ☐ Female Insurance Phone: _____
Name: _____ Policy number: _____
DOB (mm/dd/yy): _____ Group number: _____
Social security #: _____
Additional insurance: _____

I authorize the release of any medical information necessary to process my claim(s).

I authorize payment of medical benefits to White Pine Holistic Medicine – Sally Haley, MD.

Signature _____ Date _____ Signature _____ Date _____

Financial agreement

I claim full financial responsibility for services provided at White Pine Holistic Medicine and I understand that payment is required in full at the time of service.

Signature _____ Date _____

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Policies

Please review this page and bring it to your first appointment, to be signed at the office.

1. **Medical Emergencies.** If you have a medical emergency, you should call 911 immediately or go to the nearest emergency room. Do not rely on online communications and information for urgent medical care. White Pine Holistic Medicine does not offer emergency care.

2. **Fees.** Fees for service vary according to the time we spend with you and the complexity of the problems we work on at your visit. When you make your appointment, we can give you an approximate charge based on the estimated time of the visit. Any outstanding balance will be due on or before your next scheduled visit, unless otherwise arranged with our office. We expect payment at the time of each visit in cash, check, MasterCard or Visa. We must charge $25 for returned checks.

3. **Third party fees.** Laboratories, x-rays and consultants outside White Pine Holistic Medicine will send their bills to you directly. These may include any type of analysis done outside our office.

4. **Cancellation policy.** We have a 24-hour cancellation policy. If you must cancel or reschedule an appointment, please notify us as soon as possible so that other patients can be seen. If you cancel with less than 24 hours notice, or do not show up for your visit, you may be charged. After hours, messages can be left on our voicemail.

We hope these guidelines are helpful. It is our goal to be as clear as possible about these expectations to avoid confusion and misunderstanding.

If you have any questions that are not answered here, please feel free to call our office at (207) 798-5907 before your appointment.

We always appreciate your comments about how our services can better meet your needs.

Sincerely,

Providers and Staff
White Pine Holistic Medicine

By my signature, I certify that I understand and agree to the above policies.

_____
Signature
(patient or guardian)

_____
Date

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Consent for treatment

I understand that Dr. Haley is a consultant for complementary medical services to include homeopathy, nutritional medicine, and acupuncture. I further understand that Dr. Haley is not a primary care physician and offers only complementary medicine.

I am strongly advised that I must maintain a relationship with a primary care physician for conventional tests, screenings, physical exams and treatment; because Dr. Haley will not be providing these services to me.

[ ] Name of primary care physician: _____
Phone Number: _____
Address: _____

[ ] I (printed name) _____ have had explained to me the implications and limitations of integrative and homeopathic medical care and choose to receive it without conventional care from a primary care physician.

Permission is hereby given to Sally D. Haley, M.D. to render only complementary medical services (homeopathy, nutritional medicine, acupuncture) to me.

_____
Signature
(patient or guardian)

_____
Date