Patient: _____ Date: _____

Address: _____

_____

_____

Insurance No.: _____

To whom it may concern,

This is to certify that _____ has been a patient of mine since_____. I have treated him/her for the following diagnoses:

Major Depressive Disorder: Single episode (☐F32.9), Recurrent (☐F33.9), In remission, unspecified (☐F33.40), Bipolar I Disorder (☐F31.9), Bipolar II Disorder (☐F31.81)
Circadian Rhythm Sleep-Wake Disorders: Delayed Sleep Phase type (☐G47.21), Advanced Sleep Phase Type (☐G47.22), Irregular sleep-wake type (☐G47.23), Shift work type (☐G47.26), Unspecified (☐G47.20); Insomnia disorder (☐G47.00), Hypersomnolence disorder (☐G47.1), Other specified sleepwake disorder (☐G47.8), Unspecified sleep-wake disorder (☐G47.9)
Attention-deficit/hyperactivity disorder: Predominantly inattentive presentation (☐F90.0), Unspecified attention deficit/ hyperactivity disorder (☐F90.9)

In order to administer light therapy effectively, a quality light box, such as those manufactured by Northern Light Technologies is required (see attached invoice). Light therapy is a mainstream type of psychiatric treatment, described in: The Task Force Report of the American Psychiatric Association: Treatment of Psychiatric Disorders, Vol. 3, pages 1890-1896, APA Press, 1989. The experience of clinicians who have used it for patients indicates that it saves money by reducing the number of doctors' visits and laboratory investigations of persistent symptoms, as well as the indirect costs of lost productivity.

The use of a Northern Light Technologies light box should be regarded as a medical necessity, to be used in preference to or in combination with other forms of treatment, but also as a means of reducing overall medical costs.

Sincerely,
Doctor's Name: _____ Doctor's Signature: _____

Northern Light Technologies
8971 Henri Bourassa W.
Montreal, Qc., Canada
H4S 1P7