

WELCOME!

On behalf of our staff, we welcome you to our office. We are pleased that you have selected Alder Health Services to care for your behavioral health needs and we look forward to establishing a therapeutic relationship with you.

We want you to know that we are committed to providing you with the highest quality of care in the gentlest, most efficient and enthusiastic manner possible. We pride ourselves on making healthcare a pleasant and inclusive experience for you, while delivering the best treatment in a warm welcoming environment. Regular office visits are a minimum of 30 minutes and new patient visits are even longer. We want to take the time you need to make your visit meaningful.

Our office is open most Mondays from 8:30am until 8pm and Tuesdays through Fridays 8:30am until 5pm. Outside of normal business hours, you are still welcome to call us at 717-233-7190 and you will be directed to our answering service where they will be happy to take messages for our staff. If it is an urgent situation, we have one of our providers on call every single week for your convenience. Medication refills require a minimum of 72 hours (3 days) notice. Calling us when you pick up your last refill at the pharmacy will assure that we have plenty of time to address your needs and make sure you don't run out of medication.

We offer **FREE** STD/HIV testing and treatment every Wednesday evening from 4pm until 8pm, among many, many other services for our community.

Feel free to contact our friendly and knowledgeable front office staff if you have any questions or inquiries.

Sincerely,

The Providers and Staff of Alder Health Services



The information requested in this form, and any information subsequently gained for your medical record, is confidential and protected under applicable federal and state laws. Your written consent will be required for release of information, except in the case of a court order.

Legal Name First	Middle Name or Initial	Last	Preferred Name
Legal Sex Required for insurance billing and legal entities. <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (MM/DD/YYYY)	Social Security Number

Primary Phone <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work Okay to leave message <input type="checkbox"/> ()	Secondary Phone <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work Okay to leave message <input type="checkbox"/> ()	E-Mail Address <input type="checkbox"/> Register for patent portal
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Address Street	City	State	ZIP Code
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Language(s) Spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Portuguese <input type="checkbox"/> Other: _____	Race <input type="checkbox"/> American/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to Specify	Ethnicity <input type="checkbox"/> Hispanic/Latin American <input type="checkbox"/> Not Hispanic/Latin American	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered (Domestic Partner) <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____
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Gender Identity <input type="checkbox"/> Male (including Transmasculine) <input type="checkbox"/> Female (including Transfeminine) <input type="checkbox"/> Non-binary	Assigned Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female
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Preferred Pronouns <input type="checkbox"/> He, him, his <input type="checkbox"/> She, her, hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Other	Sexual Orientation <input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other: _____
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Guardian Name (patients under 18 ONLY)	Guardian Phone ()
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Emergency Contact Name	Relationship
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Home Phone ()	Mobile Phone ()
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Employer <input type="checkbox"/> Unemployed	Employer Phone ()
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State ID / Driver's License Number *must provide card	State Issued	Expiration Date (MM/DD/YYYY)
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Preferred Pharmacy	Preferred Laboratory
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Preferred Imaging Facility	How did you hear about us? <input type="checkbox"/> Advertisement <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____
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Insurance *must provide card <input type="checkbox"/> Uninsured <input type="checkbox"/> Interested in meeting with a Billing Specialist	Policy Holder
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Policy/Group Number	Issue Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
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I certify that the above information is true and correct to the best of my knowledge.

Client Signature:

Date:



CLIENT RIGHTS AND RESPONSIBILITIES

Clients have the freedom to obtain services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services.

Clients have the right to confidentiality of healthcare information.

Clients have the right to participate in healthcare decision-making, including the right to consent to or refuse treatment.

Clients have the right to know the names, titles, and qualifications of staff members serving them.

Clients have the right to information about Alder Health's operations and services, including hours of service, fees, and payment policies.

Clients have the right to be informed about procedures for giving feedback on services, including how to make a suggestion and how to make a formal complaint.

Clients are responsible for participating as active members of their health care team and be active participants in the services in which they elect to enroll.

Clients are responsible for respecting the time and resources provided by the Agency. Scheduled appointments must be cancelled 24 hours in advance in order to avoid a fee.

Clients are responsible for understanding their insurance benefits and providing accurate and current insurance information.

Clients are responsible for making timely payments of all charges and deductibles.

I, _____, the undersigned, have received a copy of Alder Health's Client Rights and Responsibilities. I have carefully read and fully understand all information outlined in this policy.

Client Signature

Date



FINANCIAL POLICY

Self-Pay: All clients who pay out-of-pocket are expected to **pay in full at the time of service.** ____ Client Initials

Forms of Payment: Alder Health agrees to provide health services in return for a fee. Cash, personal check, debit cards, Visa, Master Card, or Discover cards are acceptable forms of payment. ____ Client Initials

Returned Checks: There is a \$25.00 service charge for all returned checks. ____ Client Initials

Payment Plans: Alder Health recognizes that there are circumstances in which individuals experience financial burden. If a client is unable to pay for a visit at the time of service, we offer a 1-time payment plan that can be paid monthly during a 6-month period at a 0% interest rate. It is the client's responsibility to make timely payments if entered in to a payment plan agreement and all fees for service following the signing of the payment plan agreement must be paid in full at the time of service. ____ Client Initials

Health Insurance: Insurance policies are a contract between a client and their insurance company. If clients participate in an insurance plan accepted by Alder Health, the client is responsible for providing the information necessary to submit claims on their behalf. ____ Client Initials

It is the responsibly and expectation that each client will pay the copay fee determined by their insurance company **at the time of service.** ____ Client Initials

Some health services provided by Alder Health may not be covered by certain insurance companies. If a bill is generated following services, it is the expectation that the client will pay this bill upon receipt. ____ Client Initials

Client understands that it is not the responsibility of Alder Health to dispute insurance claims. Client must contact the number on the back of their issued insurance card if they have questions or concerns about services covered, copay amounts, or bills received for services.
____ Client Initials

I understand that it is my responsibility to notify Alder Health Services of any changes to my insurance coverage and that I am responsible for any unpaid visits not covered by my insurance package. ____ Client Initials

Client Signature

Date

Witness Signature

Date



NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices. Alder Health Services has a Notice of Privacy Practices which describes how we may use and disclose your protected health information, how you can access your protected health information, and ways to exercise other rights concerning your protected health information. Please review our current notice prior to signing this acknowledgement and consent.

Revisions to Notice of Privacy Practices. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain. This includes information created or obtained prior to the date of the effective date of the change. Copies of revised notices will be available at the reception desk and can also be obtained by submitting a written request to our Director of Operations.

Alder Health Services
100 N. Cameron St., Ste. 201–East
Harrisburg, PA 17101-2412
Telephone: (717) 233-7190
Fax: (717) 233-7196

ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have received the Notice of Privacy Practices of Alder Health Services.

Name of Client (PRINTED)

Signature of Client

Date



**EMERGENCY CONTACT
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

Client Legal Name: _____ Date of Birth: _____

This Protected Health Information is to be used/disclosed to Alder Health Services, and to:

Emergency Contact Name _____

Address: _____

Home Phone: _____ Mobile Phone: _____

I understand this information to be used/disclosed for purpose of:

Emergency purposes

Inability to reach by telephone, mail, or e-mail

I understand that my records may contain information regarding my mental health, substance use history, sexuality, and HIV/AIDS status. I make this authorization voluntarily. I understand that Alder Health Services may not condition treatment on my signing this authorization. I understand that I may inspect and copy the information to be used or disclosed, as provided by federal patient privacy regulations. I understand that this authorization carries with it the potential for the intended recipient to release the information in this disclosure and no longer protected by federal privacy laws. I understand the nature of this authorization. I understand that federal privacy regulations referred to in this authorization may be found at 45 C.F.R. sections 160 and 164.

Signature of Client/Guardian/Caregiver

Date

Relationship to Client

Signature of Witness

Date

Accepted copy of this form: YES / NO



CONSENT FOR TREATMENT

I attest that I am competent and have the right to consent for treatment, and I hereby give my consent to treatment and authorize Alder Health Services to treat me for any medical or mental health condition, provided that the provider has explained to me my condition, the treatment procedures, alternative methods of treatment, foreseeable risks of any treatment, and any undesirable results. I further authorize the care provider to perform any additional or different treatment that is thought necessary should, during treatment, a condition be discovered that was not previously known.

I have carefully read and fully understand this informed consent form and all of my questions have been adequately answered.

Client Signature

Date

Client Printed Name



LATE ARRIVAL POLICY

Alder Health's providers, medical assistants, and staff aim to make your visit a pleasurable one. In an effort to serve you better, we ask for your prompt arrival to appointments and proper notice for any cancellation.

We make every effort to be on time. Unfortunately, when even one client arrives late, it can throw off the entire schedule. If a client is more than 10 minutes late for an appointment, the appointment may need to be rescheduled. You may be given the option to wait for another appointment time on the same day, but priority will be given to clients who arrive on time.

We will try to accommodate late clients as best as possible, but cannot compromise the quality and timely care provided to other clients.

We ask that you plan to arrive 10 minutes prior to your scheduled appointment in order to complete the registration and rooming process.

Alder Health appreciates your compliance and understanding of this policy.

Client Signature

Date



INTAKE ASSESSMENT

NAME: _____

DATE: _____

What are the concern(s) for which you are seeking help?

What are your treatment goals?

Current Symptoms Checklist: (check once for any symptom present, twice for major symptoms)

- | | | |
|---|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Loss of Interest | <input type="checkbox"/> Increased risky behavior | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> _____ |

Have you ever had feelings or thoughts that you did not want to live? Yes No

Do you **currently** feel that you don't want to live? Yes No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

List all current prescription medications and how often you take them:

Medication Name	Dosage
_____	_____
_____	_____
_____	_____

Current Medical Concerns/Problems: _____

Allergies: _____

Have you ever abused prescription medications? Yes No

If yes, which ones and for how long? _____



Have you used any street drugs in the past 3 months? Yes No

If yes, which ones? _____

Tobacco History:

Have you ever smoked cigarettes? Yes No

Currently? Yes No

Quit? Yes No

How many packs per day on average? _____ How many Years? _____

Have you ever had Outpatient Treatment before: Yes No

Have you ever been Hospitalized? Yes No

Reason(s):

Where: _____

Date(s): _____

Your Exercise Level:

Do you exercise regularly Yes No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder Yes No Depression Yes No

Anxiety Yes No Suicide Yes No

Schizophrenia Yes No Substance Abuse Yes No

List your siblings and their ages:

What were/are your parent's occupations?

What is your relationship with your family?



Are your parents married or divorced?

Have you ever been abused (emotionally, sexually, physically or by neglect)?

Yes No

Educational History

Highest grade completed _____ Where? _____

Did you attend college? Yes No Where? _____

What is your highest educational level or degree attained? _____

Occupational History

Are you currently: Working Student Unemployed Disabled Retired

What is your occupation?

Have you ever served in the Military? Yes No If so, what branch? _____

Relationship History and Current Family:

Are you currently: Married Partnered Divorced Single Widowed Other: _____

Are you sexually active? Yes No

Who do you have sex with? Men Women Both

How would you identify your sexual orientation?

Lesbian Gay Bisexual Straight/Heterosexual Asexual Pansexual Other _____

Do you have any children? Yes No

If Yes, age and gender: _____

Describe your relationship with your children: _____

What is your current gender Identity? (check all that apply)

Male Female Trans male/Trans man Trans female/Trans woman

Genderqueer/Gender non-conforming Different identity not listed: _____

Is there anything else you would like us to know?

What do you consider your strengths?

What do you consider your weaknesses?
