Alder Health Services

Welcome to Alder Health Services. The Health Center team is committed to provide you with the highest quality medical and mental health services. We will work together to coordinate the services you need and provide the best care possible. The entire Health Center team is dedicated to your health and well-being and respects the unique needs of each patient.

As new patient, you can save time during your first appointment by completing the New Patient Registration Form prior to your visit. Completing the form before you arrive helps the assist the staff in making sure we have all the information *we* need to provide you with quality care and treatment. The form can be completed by hand, or on-line at www.alderhealth.org/newpatient. If you have any questions, please contact our office at 717-233-7190, ext. 237.

We are pleased that you have chosen Alder Health Services for your healthcare needs and look forward to seeing you soon.

Sincerely,

The Providers and Staff of the Alder Health Services Health Center

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.

Legal Name First	Middle Name or Initial	Last	**Preferred Name**
Legal Sex Required for insurance billing and legal entities. Male Female		**Date of Birth** (MM/DD/YYYY)	**Social Security Number**

Primary Phone Mobile Home Work Okay to leave a detailed message	**Secondary Phone** Mobile Home Work Okay to leave a detailed message	**E-Mail Address** Register for patent portal
Address Street	City	State ZIP Code

Language(s) Spoken	**Race**	**Ethnicity**	**Marital Status**
English Spanish French Portuguese Hindi Other: _____	American/Alaskan Native Asian Black Hawaiian/Pacific Islander White Decline to Specify Other	Hispanic/Latin American Not Hispanic/Latin American	Single Married Partnered (Domestic Partner) Legally Separated Divorced Widowed Other: _____

Gender Identity Male (including Transmasculine) Female (including Transfeminine) Non-binary	**Assigned Sex at Birth** Male Female
Preferred Pronouns He, him, his She, her, hers They, Them, Theirs Other	**Sexual Orientation** Lesbian Gay Heterosexual Bisexual Other:

Preferred Pharmacy	**Would you like to use our in house pharmacy (CCN) ?** YES NO	
Emergency Contact Name	**Emergency Contact Phone**	**Relationship to patient:**

Authorization for Release of Information:

May we leave test results via voicemail? Yes No

Who may receive information on your behalf regarding test results?

Name: _____ Relationship: _____

I certify that the above information is true and correct to the best of my knowledge.

_____ _____

Patient Signature: **Date:**

By signing above, I verify my identity entered above and that all responses are truthful and represent my knowledge of the applicant. In place of your signature, please type your full legal name:

Alder Health Services

ALDER HEALTH SERVICES NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES, PRIVACY PRACTICES AND FINACIAL POLICY

PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the freedom to obtain services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services.
Patients have the right to the confidentiality of healthcare information.
Patients have the right to participate in healthcare decision-making, including the right to consent to or refuse treatment.
Patients have the right to know the names, titles, and qualifications of staff members serving them.
Patients have the right to information about Alder Health's operations and services, including hours of service, fees, and financial policies.
Patients have the right to know how to provide feedback on services, including how to make a suggestion and how to make a formal complaint.
Patients 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.
Patients are responsible for respecting the time and resources provided by Alder Health. Patients must arrive on time for their appointments and appointments must be canceled 24 hours in advance in order to avoid discharge.
Patients are responsible for arriving on time in order to be seen for their scheduled appointment.
Patients are responsible for understanding their insurance benefits and providing accurate and current insurance information.
Patients are responsible for making timely payments of all charges.

Initials:_____

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.

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.

Initials:_____

FINANCIAL POLICY

Self-Pay
Alder Health understands that not every patient has medical insurance coverage. All patients who pay out-of-pocket are expected to *pay in full at the time of service*.

HRT Flat Rate
Alder Health does not participate in every available insurance program. In recognition of this, we offer a self-pay program to medical patients seeking hormone replacement therapy (HRT) at a cost of $100 for the initial visit and $75 for each follow-up visit.

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.

Returned Checks
There is a $25.00 service charge for all returned checks.

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.
It is the expectation that each client will pay the copay fee determined by their insurance company *at the time of service.*
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.
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.
I understand that it is my responsibility to notify Alder Health of any changes to my insurance coverage and that I am responsible for any unpaid services not covered by my insurance package.

Laboratory Fees
Patient may choose which laboratory they would like their specimens sent to for processing (Quest, Pinnacle, MDL). It is the Patient's responsibility to pay any laboratory fees not covered by insurance.

Initials:_____

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

_____ _____
Patient Signature Date

_____
Patient Printed Name

By signing above, I verify my identity entered above and that all responses are truthful and represent my knowledge of the applicant. In place of your signature, please type your full legal name:

Alder Health Services

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 consent form and all of my questions have been adequately answered.

By signing below, I verify my identity entered above and that all responses are truthful and represent my knowledge of the applicant. In place of your signature, please type your full legal name:

_____ _____

Printed Patient Name Date

_____

Patient Signature

TELEMEDICINE CONSENT

Due to the Covid-19 pandemic, currently we offer telehealth services via Doxy.me.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of primary care may be available to me, and that I may choose one or more of these at any time.
5. I understand that it is my duty to inform my healthcare providers involved in my medical/psychiatric care.
6. I understand that I may expect the anticipated benefits from the use of telelmedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, have discussed it with my medical provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ to use telemedicine in the course of my diagnosis and treatment.

Please send Doxy.me contact link via Text Message Email_____

Signature of Client: _____ Date: _____

Print Name: _____

If authorized signer, relationship to patient: _____

Alder Health Services

ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions for feel uncomfortable answering them, leave them blank.

PATIENT LEGAL NAME: _____ PATIENT PREFERRED NAME: _____

PATIENT DATE OF BIRTH: _____ TODAY'S DATE: _____

What would you like to talk to your doctor about today? _____

_____

When was your last physical exam?_____

Please list any medication allergies or reactions:

Allergy:	Allergic Reactions:

Please check to indicate if you have ever had the following conditions:

Abnormal PAP smear	Depression	Hyperthyroidism
Anemia	Diabetes	Hypothyroidism
Anxiety Disorder	Emphysema	Kidney Disease
Arrhythmia	GERD (reflux/heartburn)	Seizures
Asthma	Heart Attack	Stroke
Cancer:_____	Hepatitis A B C	Substance Abuse
Clotting Disorder	High Blood Pressure	Tuberculosis
Congestive Heart Failure	HIV/AIDS	UTI (urinary tract infection)

Other: _____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / Reason for hospitalization :	Location/ Date:
_____	_____
_____	_____
_____	_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

_____

_____

Do you feel there is something seriously wrong with your body? YES NO
If you checked yes please explain here:

_____

Alder Health Services

Please list all medications, including vitamins, medical maujauana, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Name of Medication	Strength (Dose)	How many I take	How often I take it
Example	*50 mg*	*1 pill*	*Twice a day*

Additional medications: _____

TOBACCO USE:

Never Smoked

Former Smoker

Years of tobacco use:_____ Age started smoking:_____

Packs per day: _____

Quit date:_____

Current Every Day Smoker

Years of tobacco use:_____ Age started smoking:_____

Packs per day: _____

Types of tobacco I use(d): cigarettes cigars pipe smokeless (chew/snuff) E-cigarettes/ vape

ALCOHOL USE:

I drink alcohol I do not drink alcohol

How much alcohol I drink: _____ glasses of wine per week _____ cans of beer per week

_____ shots of liquor a week _____ standard drinks per week

Have you ever felt that you should cut down on your drinking? Yes No

DRUG USE:

Have you regularly use(d) illegal drugs? Yes No Quit (date: _____)

Drugs use(d): _____

Check any of the following diseases that run in your family and who had it:

	MOTHER	FATHER	SISTER	BROTHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	CHILD	OTHER (please specify)
ALCOHOL ABUSE	☐	☐	☐	☐	☐	☐	☐	☐	☐	
ANXIETY	☐	☐	☐	☐	☐	☐	☐	☐	☐	
CANCER	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Specify: Cancer Type										
DEPRESSION	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DIABETES	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG ABUSE	☐	☐	☐	☐	☐	☐	☐	☐	☐	
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐	☐	☐	
HIGH CHOLESTEROL	☐	☐	☐	☐	☐	☐	☐	☐	☐	
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐	
OSTEOPOROSIS	☐	☐	☐	☐	☐	☐	☐	☐	☐	
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐	☐	☐	☐	
STROKE	☐	☐	☐	☐	☐	☐	☐	☐	☐	
HYPOTHYROIDISM	☐	☐	☐	☐	☐	☐	☐	☐	☐	
HYPERTHYROIDISM	☐	☐	☐	☐	☐	☐	☐	☐	☐	

I live with (choose all that apply):

alone
parents
spouse/ significant other
friends/family
child/children
other

I feel safe living by myself, or with the ones I currently reside with:

yes_____ no_____

Current Work Status:

Disabled	Full-time	Part-time
Retired	Not Employed	Self Employed
Full-time student	Part-time Student	

Where do you work/go to school? _____

What do you do for work/school? _____

Do you exercise regularly? YES NO Describe what you do for exercise:_____

Diet (please check all that apply):

I do not have a specific diet	Diabetic Diet	Cardiac Diet	Gluten Free
High Fiber	Lactose Free	Low Carb	Low Fat
Renal Diet	Vegan	Vegetarian	

Other (please specify) _____

Over the last two (2) weeks how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things: Not at all Several days More than half the days Nearly every day

Feeling down, depressed or hopeless: Not at all Several days More than half the days Nearly every day

Are you sexually active? YES NO

With? MEN WOMEN BOTH OTHER _____

Current Birth Control/Protection Used:

abstinence	pulling out (coitus interruptus)	male condoms	female condoms
diaphragm	emergency contraception	implant	injections
IUD	the pill (oral contraception)	the patch	post-menopausal
rhythm method	spermicide	sponge	ring
surgical vasectomy/ tubes tied	none	other (specify) _____	

Do you have children? YES NO

How many? _____

Have you ever been pregnant? YES NO NOT APPLICABLE

How many times? _____
Number of miscarriages? _____
Number of abortions? _____

Do you have menstrual periods? YES NO NOT APPLICABLE

What age did your period start? _____ If not, at what age did they stop? _____

Are your periods regular? YES NO Date of last period: _____

Have you ever had a PAP smear? YES NO Have you ever had an abnormal PAP smear? YES NO

Last completed PAP: _____

Sexual and Reproductive Health Program

Coverage and Income Assessment Form

Services related to this program can include pregnancy testing, pre-conception counseling, birth control options, emergency contraception, STD and HIV Testing.

Alder Health receives federal monies to provide free and reduced fee services to low-income, uninsured, and underinsured individuals. All patients are required to provide household and income information.

This information is strictly self-report and will not undergo a verification process, unless:

i. if you are an employee of Alder Health Services your income will be assessed
ii. if you are receiving other Alder Health Services that require income verification, this information can be used for this assessment.

I am covered by insurance and have no concerns about confidentiality. It is okay for the Agency to bill my insurance company.

OR

I am covered by insurance but want to keep my visit to this agency private. I do not want the Agency to bill my insurance company. I understand that I may be responsible for cost associated to this visit.

I have no insurance coverage.

FAMILY SIZE 0

GROSS MONTHLY HOUSEHOLD INCOME: $_____

- I voluntarily agree to participate in the Family Planning Program, and assert that Family Planning services were not presented as a requirement or prerequisite for any other program or service.
- I have been informed that this clinic assures patient confidentiality and provides safeguards against the invasion of personal privacy, as required by the Privacy Act of 1974 and Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. All information which may be identified with me will be considered privileged and confidentiality will be maintained.

By signing below, I verify my identity entered above and that all responses are truthful and represent my knowledge of the applicant. In place of your signature, please type your full legal name:

By signing this document below, I acknowledge that I have read, understand and agree with the above information.

_____ _____

PATIENT SIGNATURE DATE

I decline to give this information. *I understand that in order to qualify to receive services, I must provide the above information.*

(This information must be collected annually).

Please click the button to email your completed form

Email

Alder Health Services