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 medical 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 health 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 medical 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.

Illness happens. It happens at the most inconvenient times and at the last minute. We understand. That's why we have sick appointments available most days so we can ensure you are well as quickly as possible. Therefore, if you wake up with the "sniffles", a backache, fever, a nasty cut, or other non-life threatening problem, call us **FIRST** and we will see you as soon as mutually convenient. We want you to avoid the long waits in the emergency department and we can handle most things in the office.

We don't just provide primary care services. We offer hormone replacement therapy and counseling services for transgender individuals so we can help aid in the journey of becoming the **REAL YOU**. 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. ☐ Male ☐ Female		**Date of Birth** (MM/DD/YYYY)	**Social Security Number**

Primary Phone ☐ Mobile ☐ Home ☐ Work Okay to leave message ☐ ( )	**Secondary Phone** ☐ Mobile ☐ Home ☐ Work Okay to leave 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 ☐ Other: ______________________	☐ American/Alaskan Native ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Decline to Specify	☐ Hispanic/Latin American ☐ Not Hispanic/Latin American	☐ Single ☐ Married ☐ Partnered (Domestic Partner) ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Other: ________________

Gender Identity	**Assigned Sex at Birth**
☐ Male (including Transmasculine) ☐ Female (including Transfeminine) ☐ Non-binary	☐ Male ☐ Female

Preferred Pronouns	**Sexual Orientation**
☐ He, him, his ☐ She, her, hers ☐They,Them,Theirs ☐ Other	☐ Lesbian ☐ Gay ☐ Heterosexual ☐ Bisexual ☐ Other: ___________

Guardian Name (patients under 18 ONLY)	**Guardian Phone** ( )

Emergency Contact Name	**Relationship**
Home Phone ( )	**Mobile Phone** ( )

Employer ☐ Unemployed	**Employer Phone** ( )

State ID / Driver's License Number *must provide card	**State Issued**	**Expiration Date** (MM/DD/YYYY)

Preferred Pharmacy	**Preferred Laboratory**
Preferred Imaging Facility	**How did you hear about us?** ☐ Advertisement ☐ Word of Mouth ☐ Hospital ☐ Other: __________________

Insurance *must provide card ☐ Uninsured ☐ Interested in meeting with a Billing Specialist	**Policy Holder**	
Policy/Group Number	**Issue Date** (MM/DD/YYYY)	**Expiration Date** (MM/DD/YYYY)

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

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

ADULT HEALTH QUESTIONAIRE

You're 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 NAME: ____

PATIENT DATE OF BIRTH: ________________________ TODAY'S DATE: _____________________

What would you like to talk to your doctor about today? __________________________________
____

Please list any medication allergies or reactions: _______________________________________
____
____

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

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Depression
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Arrhythmia
- ☐ Sexually Transmitted Infection (STI): ______________________________
- ☐ Eye Problems: ________________________________
- ☐ Cancer: ___________________________________
- ☐ Other: ____

Please list any surgeries of 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:
____
____

When was your last physical exam?: ____

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

Medicare Name:	Dosage:
______________________________________	____________________________
______________________________________	____________________________
______________________________________	____________________________

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

	MOTHER	FATHER	SIBLING	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	CHILD	OTHER
ALCOHOLISM OR DRUG USE								
CANCER								
DIABETES								
HEART DISEASE								
HIGH BLOOD PRESSURE								
HIGH CHOLESTEROL								
OSTEOPOROSIS								
MENTAL ILLNESS								
STROKE								
THYROID DISEASE								
OTHER								

Other Comments: ____
____
____

Do you smoke tobacco products? ☐ YES ☐ NO ☐ QUIT
Number of cigarettes each day? ______________________
For how many years? ______________________________
Other forms of tobacco use? _________________________

Do you drink alcohol? ☐ YES ☐ NO ☐ QUIT
How much do you drink? ___________________________
How often do you drink? ____________________________
Have you ever felt that you should cut down on your drinking? _________________________

Have you regularly used other drugs? ☐ YES ☐ NO ☐ QUIT

Are you currently married or living with a significant other? ☐ YES ☐ NO
Who lives with you at home? ________________________

Do you exercise more than 2 times per week? ☐ YES ☐ NO

Do you often feel sad or depressed? ☐ YES ☐ NO

Do you feel there is something seriously wrong with your body? ☐ YES ☐ NO

Are you having money problems which limit your access to food, shelter, or medical care? ☐ YES ☐ NO

Are you sexually active? ☐ YES ☐ NO
With? ☐ MEN ☐ WOMEN ☐ BOTH

Do you have children? ☐ YES ☐ NO
How many? ___________________________________

Do you use a form of birth control? ☐ YES ☐ NO
Which type and brand? _________________________

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
If not, at what age did they stop? __________________
If yes, are your periods regular? ☐ YES ☐ NO

Other Comments: ____
____
____
____

EMERGENCY CONTACT
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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 the 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 Patient/Guardian/Caregiver Date

____
Relationship to Patient

(This form will expire 1 year from date of signature).

<u>Family Planning Program Coverage and Income Assessment Form</u>

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 striclty self-report and <u>will not</u> 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.**

☐ **I am covered by insurance but want to keep my visit to this agency private. I <u>do not</u> 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: 1 2 3 4 5 6 7 8 9 10+

GROSS MONTHLY <u>HOUSEHOLD</u> 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.

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

_________________________________ _________________________

PATIENT SIGNATURE DATE

(This information must be collected annually).