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 welcoming environment. Regular office visits range from 20-30 minutes and new patient visits range from 40-60 minutes. 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 night 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. 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; we also offer hormone replacement therapy, family planning, and mental health services. In addition, we have a wellness center with drop-in hours and scheduled classes, a clothing bank, and **FREE** STI/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.

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

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 ☐ 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

and protected under applicable federal and state laws.

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

Preferred Pharmacy	**Preferred Laboratory**
Would you like to use CCN Pharmacy? ☐ YES ☐ NO	**Preferred Imaging Facility**

Insurance *must provide card ☐ Uninsured	**Policy Holder Name**	
Policy/Group Number	**Issue Date** (MM/DD/YYYY)	**Expiration Date** (MM/DD/YYYY)

Alder Health Services 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. ☐ I decline. I understand that in order to qualify for free or discounted services and medications, I must provide this indormation.	
Family Size (Circle): 1 2 3 4 5 6 7 8 9 10+	**Gross Monthly Income: $**__________

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

Patient Signature: ______________________________ **Date:** ____________________

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.

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.

____ ____________________

Patient Signature Date

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*.

> ☐ Check this box if you request that your self-pay service not be disclosed to your health plan (payer) in accordance with HIPPA's Privacy Rule CFR 164.522(a)(1)(vi). This will only apply to self-pay services.

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.

____ ____________________

Patient 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 Patient (PRINTED)

____ ____
Signature of Patient Date

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).

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.

____ ____________________

Patient Signature Date

____

Patient Printed Name

(This form must be signed once per calendar year).

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 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
☐ Anemia
☐ Anxiety Disorder
☐ Arrhythmia
☐ Asthma
☐ Cancer:________________
☐ Clotting Disorder
☐ Congestive Heart Failure
☐ Depression
☐ Diabetes
☐ Emphysema
☐ GERD (reflux/heartburn)
☐ Heart Attack
☐ Hepatitis ☐ A ☐ B ☐ C
☐ High Blood Pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Disease
☐ Seizures
☐ Sexually Transmitted Infections
☐ Stroke
☐ Substance Abuse
☐ Tuberculosis
☐ UTI (urinary tract infection)

☐ 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:

____

____

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

____

Please list all medications, including vitamins, 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 GRANDMOTHE	PATERNAL GRANDFATHER	MATERNAL GRANDMOTHE	MATERNAL GRANDFATHER	CHILD	OTHER (please specific)
ALCOHOL ABUSE										
ANXIETY										
CANCER Specify:										
DEPRESSION										
DIABETES										
DRUG ABUSE										
HEART DISEASE										
HIGH BLOOD PRESSURE										
HIGH CHOLESTEROL										
KIDNEY DISEASE										
OSTEOPOROSIS										
MENTAL ILLNESS										
STROKE										
HYPOTHYROIDISM										
HYPERTHYROIDIS M										
OTHER Specify:										

I live with (choose all that apply):

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

Alder Health Services

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 Appox Date of last menses: ___________________________

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

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 stricIty 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.**

☐ **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: 1 2 3 4 5 6 7 8 9 10+

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 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).