

## 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.

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

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

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Client Signature

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Date

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Client Printed Name



## 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 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:

- |  |  |   |                                       |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure                         | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Hepatitis                                   | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Seizures     |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Depression                                  | <input type="checkbox"/> Emphysema                |                                       |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Coronary Artery Disease                     | <input type="checkbox"/> Congestive Heart Failure |                                       |
| <input type="checkbox"/> Arrhythmia          | <input type="checkbox"/> Sexually Transmitted Infection (STI): _____ |   |                                       |
| <input type="checkbox"/> Eye Problems: _____ | <input type="checkbox"/> Cancer: _____                               |   |                                       |
| <input type="checkbox"/> 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_