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 online 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

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 ☐ English ☐ Spanish ☐ French ☐ Portuguese ☐ Hindi ☐ Other: _____	**Race** ☐ American/Alaskan Native ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Decline to Specify ☐ Other	**Ethnicity** ☐ Hispanic/Latin American ☐ Not Hispanic/Latin American	**Marital Status** ☐ 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	**Emerency 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:**

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

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.

_____ _____

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

Alder Health Services

Behavioral Health Intake Assessment

Name: _____ (pronouns_____) Date: _____

Service(s) you are seeking:

Behavioral health services
☐ Psychiatry/medication management
☐ Individual, couples, or family therapy

Access to gender affirming medical care
☐ Assessment or letter for HRT
☐ Letter for surgery

Why are you seeking this service? What are your primary concerns?

_____

What are your treatment goals?

_____

How can we help you achieve your goals?

_____

What are your strengths? *Things you're good at, what you like about yourself, qualities others appreciate about you, etc.*

_____

What are your limitations? *Things that are difficult for you, what you don't like about yourself, challenges, barriers, etc.*

_____

Mental Health

Symptoms

	No	Yes/ past	Yes/ current		No	Yes/ past	Yes/ current
Depressed mood	☐	☐	☐	Racing thoughts	☐	☐	☐
Crying spells	☐	☐	☐	Isolating from others	☐	☐	☐
Unable to enjoy activities	☐	☐	☐	Excessive energy	☐	☐	☐
Excessive guilt	☐	☐	☐	Impulsivity	☐	☐	☐
Excessive irritability	☐	☐	☐	Forgetfulness	☐	☐	☐
Fatigue	☐	☐	☐	Difficulty concentrating	☐	☐	☐
Anxious/nervous	☐	☐	☐	Delusions	☐	☐	☐
Anxiety/panic attacks	☐	☐	☐	Suspiciousness	☐	☐	☐
Excessive worry	☐	☐	☐	Hallucinations	☐	☐	☐
Change in sleep patterns	☐	☐	☐	Change in appetite	☐	☐	☐
Change in sex drive	☐	☐	☐	Increased risky behaviors	☐	☐	☐
Other:_____	☐	☐	☐	Other:_____	☐	☐	☐

To your knowledge, have you been diagnosed with, or treated for, any condition that affects your behaviors, moods, perceptions, or thoughts? ☐ Yes ☐ No
Diagnosis(es): _____

Family history of mental health conditions or substance abuse:

_____

How much do your emotions and mental health symptoms affect your day to day life?
On a scale of 0-10: _____ Comments: _____

What are your current coping skills for managing symptoms or intense emotions?

_____

What do you enjoy doing for fun or relaxation?

_____

Is religion or spirituality a part of your life? ☐ Yes ☐ No
Describe: _____

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No
How often do you have these thoughts? _____When was the most recent time? _____
Do/did you consider a plan for ending your life? ☐ Yes ☐ No

Have you ever experienced any type of abuse or another traumatic event or situation? ☐ Yes ☐ No
If yes, please provide a brief description if you are comfortable doing so:

_____

Use of non-prescribed substances in the last year

	Yes	No	How much? How often?
Nicotine	☐	☐	_____
Alcohol	☐	☐	_____
Marijuana (Medical card? Y N)	☐	☐	_____
Stimulants	☐	☐	_____
Heroin or other opiates	☐	☐	_____
Other prescription medication:_____	☐	☐	_____
Other illicit substance:_____	☐	☐	_____

Has your use of substances *ever* caused you problems? Job loss, relationship problems, health concerns, etc.
☐ Yes ☐ No Describe: _____

Please list past and current behavioral health and/or substance abuse treatment you have participated in

	No	Yes	Date(s)	Provider or facility	Treated for
Psychotherapy	☐	☐	_____	_____	_____
Psychiatric	☐	☐	_____	_____	_____
PHP/IOP	☐	☐	_____	_____	_____
Inpatient	☐	☐	_____	_____	_____

May we request records from your current and previous mental health providers? ☐ Yes ☐ No

Physical health

Medical Concerns/Problems: _____
Allergies: _____

Current medication including prescription, OTC, supplements, etc.

Name	Dosage	Frequency	Taking for

Hospitalizations

Date	Where?	Why?

Do you exercise? ☐ Yes ☐ No
What kind of exercise and how often?

_____

Is there anything you would like to change about your health?

_____

Family, relationships, and support systems

Who raised you and lived in your household when you were growing up?

_____

What is your relationship with those people like now?

_____

Who do you currently live with and what is your relationship like with them?

_____

Do you feel safe at home and in your relationships? ☐ Yes ☐ No

Relationship status: ☐ Married ☐ Partner(s) ☐ Single ☐ Other: _____

Do you have children? ☐ Yes ☐ No If yes, what are their names and ages?

_____

Who in your life is the most supportive?

_____

Is anyone in your life not supportive, or harmful to you in any way?

_____

Do you feel you have adequate social support?

_____

How do you identify your sexual orientation?
☐ Asexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Straight/Heterosexual ☐ Other_____
Are you sexually active? ☐ Yes ☐ No
Who do you have sex with? ☐ Men (including transmen) ☐ Women (including transwomen) ☐ Both ☐Other

Education/Occupation/Financial Stability

Graduated high school? ☐ Yes ☐ No Year: _____
Any education or training after high school? ☐ Yes ☐ No Describe: _____
Have you obtained a degree or certification? ☐ Yes ☐ No Describe: _____
Have you served in the Military? ☐ Yes ☐ No Describe: _____

Are you currently:

☐ Working Occupation: _____ Employer: _____

☐ In school/training/apprenticeship Where? _____ For: _____

☐ Unemployed

☐ Disabled

☐ Retired

☐ Other: _____

Are you financially secure and able to afford the things you need? ☐ Yes ☐ No

Anything else you want us to know?

_____

_____

_____

Anything you want to ask about?

_____

_____

_____

Alder Health Services

AUDIT (Alcohol Use Disorder Identification Test)

How often do you have a drink containing alcohol?	Never	Monthly	2-4 times monthly	2-3 times weekly	4 or more weekly
How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often during the last year have you found that you were unable to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often during the last year have you felt guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or most days
Have you or someone else been injured as the result of your drinking?	No	Yes, but not in the last year		Yes, during the last year	
Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, before the last year		Yes, during the last year	

Saunders JB, Aasland OG, Babor TF, De La Fuente JR, Grant M. 1 993. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-11.

DAST-10 (Drug Use Questionnaire)

These questions refer to the past 12 months.

Have you used drugs other than those required for medical reasons?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Are you always able to stop using drugs when you want to?	Yes	No
Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
Do you ever feel bad or guilty about your drug use?	Yes	No
Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
Have you neglected your family because of your use of drugs?	Yes	No
Have you engaged in illegal activities in order to obtain drugs?	Yes	No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

BDI-II

Alder Health Services

Name: _____ Date: _____

*Please read each group of statements carefully. Circle **one** state in each group which best described the way you have been feeling **during the past 2 weeks, including today**.*

Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that 1 can't stand it.

Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get

Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I do not enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I cannot get any pleasure from things I used to enjoy.

Guilty Feelings
0 I do not feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

Punishment Feelings
0 I do not feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

Self-Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

Self-Criticalness
0 I do not criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

Suicidal Thought or Wishes
0 I do not have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

Crying
0 I do not cry any more than used to
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying but I can't.

Agitation
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated I have to keep moving or doing something.

Loss of Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It is hard to get interested in anything.

Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

Worthlessness
0 I do not feel I am worthless.
1 I do not consider myself as worthwhile or useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

QUESTIONS CONTINUED →

Loss of Energy
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I do not have enough energy to do very much.
3 I do not have enough energy to do anything.

Change in Sleeping Pattern
0 I have not experienced any change in my sleeping pattern.
- - -
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
- - -
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
- - -
3a I sleep most of the day.
3b I wake up 1-2 hours early and cannot get back to sleep.

Irritability
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

Change in Appetite
0 I have not experienced any change in my appetite.
- - -
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
- - -
2a My appetite is much less than before.
2b My appetite is much greater than usual.
- - -
3a I no appetite at all.
3b I crave food all the time.

Concentration Difficulty
0 I can concentrate as well as ever.
1 I cannot concentrate as well as usual.
2 It is hard to keep my mind on anything for very long.
3 I find I cannot concentrate on anything.

Loss of Interest in Sex
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex than I used to be.
3 I have lost interest in sex completely.

Aaron T. Beck, M.D., Room 754, 3600 Market Street,
Philadelphia, PA 19104-2648

ZUNG SELF-RATING ANXIETY SCALE

Alder Health Services

Name: _____ Date: _____

*How you have been feeling **during the past week**? Circle the appropriate number for each statement*	None or a little	Some of the time	A lot of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches, neck and back pains.	1	2	3	4
8. I feel weak and get tired easily.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel faint.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers and toes.	1	2	3	4
15. I am bothered by stomachaches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4

SCORE TOTAL: _____

Adapted from Zung WWK. A rating instrument for anxiety. Psychosomatics. 1971;XII:371-379.