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 behavioral health 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 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 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.

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	**Secondary Phone**	**E-Mail Address**
☐ Mobile ☐ Home ☐ Work Okay to leave message ☐ ( )	☐ Mobile ☐ Home ☐ Work Okay to leave message ☐ ( )	☐ 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

EMERGENCY CONTACT
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Client Legal Name: ___________________________________ Date of Birth: _______________________

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 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 Client/Guardian/Caregiver Date

____
Relationship to Client

____ __________________________________
Signature of Witness Date

Accepted copy of this form: YES / NO

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

TELEPSYCHIATRY CONSENT

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 telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry 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 telepsychiatry interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of psychiatric 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 psychiatrist of any other healthcare providers involved in my medical/psychiatric care.
6. I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my psychiatrist 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 telepsychiatry in my medical care.

I hereby authorize Dr. Lawhead to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient: ________________________________ Date: __________

Print Name: ________________________________

If authorized signer, relationship to patient: ________________________________

PSYCHIATRY TREATMENT PLAN

I ________________________ (name), agree to participate in creating my individual treatment plan with Dr. Lawhead on ______________ (date). I will receive a copy of my individual treatment plan.

Client Printed Name: _____________________________________

Client Signature: ____ Date: _______________

INTAKE ASSESSMENT

NAME: ____ DATE: _____________________

What are the concern(s) for which you are seeking help?

____

____

____

What are your treatment goals?

____

____

____

Current Symptoms Checklist: (check once for any symptom present, twice for major symptoms)

☐ Depressed mood	☐ Decreased libido	☐ Crying spells
☐ Unable to enjoy activities	☐ Racing thoughts	☐ Excessive worry
☐ Sleep disturbance	☐ Impulsivity	☐ Anxiety attacks
☐ Loss of Interest	☐ Increased risky behavior	☐ Avoidance
☐ Forgetfulness	☐ Increased libido	☐ Hallucinations
☐ Change in appetite	☐ Decreased need for sleep	☐ Suspiciousness
☐ Excessive guilt	☐ Excessive energy	☐ _________________________
☐ Fatigue	☐ Increased irritability	☐ _________________________

Have you ever had feelings or thoughts that you did not want to live? ☐ Yes ☐ No

Do you **currently** feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts? ____

When was the last time you had thoughts of dying? ___________________________________

On a scale of 1 to 10, (ten being strongest) how strong is you desire to kill yourself currently?

____

List all current prescription medications and how often you take them:

Medication Name Dosage

____

____

____

Current Medical Concerns/Problems: ____

Allergies: ____

Have you ever abused prescription medications? ☐ Yes ☐ No

If yes, which ones and for how long? ____

Have you used any street drugs in the past 3 months? ☐ Yes ☐ No

If yes, which ones? ____

Tobacco History:

Have you ever smoked cigarettes? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No

Quit? ☐ Yes ☐ No

How many packs per day on average? ____________ How many Years? _________

Have you ever had Outpatient Treatment before: ☐ Yes ☐ No

Have you ever been Hospitalized? ☐ Yes ☐ No

Reason(s):

Where:

Date(s):

Your Exercise Level:

Do you exercise regularly ☐ Yes ☐ No

How many days a week do you get exercise? ________________________________

How much time each day do you exercise? ________________________________

What kind of exercise do you do? ________________________________

Family History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Suicide	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No	Substance Abuse	☐ Yes	☐ No

List your siblings and their ages:

What were/are your parent's occupations?

What is your relationship with your family?

Are your parents married or divorced?

____

Have you ever been abused (emotionally, sexually, physically or by neglect)?
☐ Yes ☐ No

Educational History

Highest grade completed _____________ Where? ____
Did you attend college? ☐ Yes ☐ No Where? ____
What is your highest educational level or degree attained? __________________________________

Occupational History

Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
What is your occupation?
Have you ever served in the Military? ☐ Yes ☐ No If so, what branch? ___________________

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed ☐ Other: _________
Are you sexually active? ☐ Yes ☐ No
Who do you have sex with? ☐ Men ☐ Women ☐ Both
How would you identify your sexual orientation?
☐ Lesbian ☐ Gay ☐ Bisexual ☐ Straight/Heterosexual ☐ Asexual ☐ Pansexual ☐ Other________
Do you have any children? ☐ Yes ☐ No
If Yes, age and gender:____

____
Describe your relationship with your children: ____

____
What is your current gender Identity? (check all that apply)
☐Male ☐Female ☐Trans male/Trans man ☐Trans female/Trans woman
☐Genderqueer/Gender non-conforming ☐ Different identity not listed:______________________

Is there anything else you would like us to know?

____
____
____

What do you consider your strengths?

____
____

What do you consider your weaknesses?

____
____