



Financial Information Form

Name (Please Print): _____ Date of Birth: ____ / ____ / ____

Social Security #: _____

Age: _____ If you are age 17 or younger, is your parent or legal guardian aware that you are a patient here at Planned Parenthood? Yes No

If you need help paying for your services, you may qualify for reduced prices based on your income because of federal funding received by Planned Parenthood. For us to help you, we need to ask about your **household size** and **income**. Please include all sources of income such as: Employment, Wages, Tips, Alimony, Child Support, Unemployment, Social Security, Disability, etc...

Please answer these 4 questions to see if you qualify for reduced payment (or, skip to 5 if you don't want help with your payment).

1 YOUR income before taxes _____ \$ _____
 a week every 2 weeks a month a year

2 OTHER'S income before taxes _____ \$ _____
(Example: Parents, Partner, Spouse, etc. that add income to your household) a week every 2 weeks a month a year

3 Total number of people living with you on this income (including you) _____

4 Do you have medical insurance? _____ No Yes

If Yes, please give your insurance card and a photo ID to staff with your completed paperwork.

5 **I do not wish to report my income information at this time.** I understand that I will need to pay the full price for my services, or any services not covered by insurance, as I will NOT be eligible for discounts.

I certify that the above information is complete and accurate.

I understand that I am financially responsible for any charges not covered by insurance.

I also understand that there will be a \$25 fee on all checks returned for insufficient funds.

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY

SLIDING SCALE: 1 2 3 4 5 6 WEEKLY INCOME: \$ _____

Verified by: _____ Today's Date: _____

STAFF INITIAL EACH MONTH THAT INFO HAS BEEN VERIFIED

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
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NO PATIENT WILL BE DENIED SERVICE DUE TO INABILITY TO PAY