

DOB

Planned Parenthood of Central North Carolina, Inc.

Toll Free 1-866-942-7762

Chart #

Chapel Hill Health Center
1765 Dobbins Drive
Chapel Hill, NC 27514

Durham Health Center
105 Newsom Street, Suite 101
Durham, NC 27704

Fayetteville Health Center
4551 Yadkin Road
Fayetteville, NC 28303

PATIENT DEMOGRAPHIC INFORMATION

First name: _____ Last name: _____

Date of Birth: _____ Age: _____ SS#: _____

For statistics reporting purposes only						
Race:	White	Black	American Indian	Asian	Native Hawaiian/Pacific Islander	Other/Unknown
	Are you of Hispanic/Latino/a origin?		Yes	No		
Marital Status:	married	separated	never married	Yrs Education completed:	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+	
	divorced	widowed				

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Where may we contact you by phone?: Home Work Cell

How should we identify ourselves? (mark one) Planned Parenthood Health Center
 Doctor's Office Pam Perez (code name)

Emergency Contact Person (required)*:

Name: _____ Relation to you: _____

Home Phone: _____ Work or Cell Phone: _____

**Confidentiality may be broken if you cannot be contacted when a life-threatening condition is suspected or detected.*

METHOD OF PAYMENT

____ Health Insurance/Medicaid: Blue Cross Blue Shield, Cigna, Wellpath or UnitedHealthcare, General Medicaid, Carolina Access (referral # required) or Family Planning Waiver (present current card)

• I, (signature) _____ authorize Planned Parenthood of Central North Carolina and its representatives to appeal services rendered by them to me should my insurance deny them.

____ Self pay (cash, check or credit card or any combination of these payment types)

____ Title X: Sliding scale program for low-income non-insured patients that covers a gynecological exam and birth control at our Durham Health Center (present proof of income)

____ I need to speak with someone about setting up a payment plan (higher rates may apply)

____ Other (explain): _____

Payment is expected when you receive services unless PPCNC agrees to submit an insurance claim on your behalf or agrees to a payment plan. We will bill you for any balance still due after the insurance carrier has responded to the claim. Full payment is due within 30 days from date of service. If payment in full is not received within 90 days from date of service you will be charged an additional \$25.00 and the claim will be sent to a collection agency.

By signing this form I attest that the insurance/income information I have provided is correct and up-to-date. I understand and agree that regardless of my method of payment I am ultimately responsible for the balance on my account for any professional services rendered that are not covered by my insurance or by the program(s) in which I am participating. Note: PPCNC will mail you a statement for any balance on your account if you are 18 years of age or older.

Signed: _____ Date: _____