

MARKETING PLAN

Where did you hear about our center: (check one only)

- Friend/Relative Doctor referral Yellow Pages Newspaper Other
 PP presentation School/college Television Magazine
 PP peer educator Internet Radio Insurance Provider

Family Size (include self, spouse, children): _____

What is your MONTHLY income (before taxes and deductions) from ALL sources? (IF MARRIED, include spouse's income)

\$ _____

Can the above address be used to receive mail if Planned Parenthood is not on the return address: Yes ___ No ___

If no, Mailing Address: _____

City _____ State _____ Zip _____

In an emergency, whom shall we contact? Name _____

Address _____ City/State _____ Zip _____

Ph # _____ Circle one: home, work, cell Relationship _____

Does this person know you are a patient here? Yes ___ No ___

Do you have private insurance coverage? Yes ___ No ___ ****If YES, please check one:**

___ covers all or some family planning services.

___ covers NO family planning services.

___ coverage unknown for family planning services.

I hereby give my permission to the employees of Planned Parenthood of Santa Barbara, Ventura and San Luis Obispo Counties, Inc. and others authorized by them to use information contained in my medical record for statistical and County Health Department reporting purposes, with the understanding that confidentiality will be maintained.

I authorize the release of any medical or other information necessary to process this claim. I also request assignment of government benefits to PPSBVSLO.

I authorize payment of medical benefits to the clinic for medical services received at PPSBVSLO.

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I understand that suspicions of child abuse and neglect, statutory rape, domestic violence and sexual assault are required to be reported according to state law.

Signed: _____ **Date:** _____

PLEASE RETURN THIS FORM TO THE FRONT DESK. THANK YOU.