

PLEASE CHECK OFF WHAT APPLIES:

I have Medical Insurance. **Primary Insurance** is MINE If NOT, the Policy Holder is: _____
Name _____ DOB _____
My relationship to the Policy Holder: Spouse Child Other _____
Secondary Insurance is MINE If NOT, the Policy Holder is: _____
Name _____ DOB _____
My relationship to the Policy Holder: Spouse Child Other _____

I have: Medicaid or FPBP (Family Planning Benefit Program). If **enrolled in FPBP**, do you have a benefit card? Yes No

YES, in the past 2 years I was pregnant and Medicaid covered my pregnancy costs but since then my Medicaid coverage has ended. (If so, you may be entitled to free services.) Date Pregnancy Ended: _____ Medicaid ID #: _____

FINANCIAL ASSESSMENT: Please answer the following questions to the best of your knowledge.

AGE: Under 20 20 or Over If Under 20, are your parents supportive of your visit here? Yes No

Are you a STUDENT: No Yes If Yes: High School College

DO YOU LIVE: Alone, or with: Parent(s) Spouse Partner Children # of _____ Roommates Other _____

IF EMPLOYED, ARE YOU: Full or Part Time Average # Hours Worked Weekly _____ Hourly Pay \$ _____

IF **NO INCOME**, please explain how you are meeting your needs (example: living with family or friends):

How much **per week** do you have for **personal spending**? _____

Please enter **GROSS MONTHLY INCOME (GMI)**. Gross = before taxes, deductions and expenses. Note: GMI = weekly pay x 4 or bi-weekly x 2.

| MONTHLY | INCOME SOURCES (please check boxes that apply) | OFFICE USE ONLY - NOTES |
|---|---|-------------------------|
| \$ | Your <input type="checkbox"/> Employment Income or <input type="checkbox"/> Unemployment Income | |
| \$ | Your <input type="checkbox"/> Spouse, <input type="checkbox"/> Partner, or <input type="checkbox"/> Parent's Income | |
| \$ | Alimony/child support received (not paid) | |
| \$ | <input type="checkbox"/> Other Income <input type="checkbox"/> Public Assistance <input type="checkbox"/> Disability <input type="checkbox"/> Social Security <input type="checkbox"/> Allowance <input type="checkbox"/> Help from family/friends | |
| \$ | Regular income and/or interest from trust funds, stocks, or other investments | |
| NUMBER OF PEOPLE SUPPORTED ON THIS INCOME? _____ | | |

PLEASE READ THE FOLLOWING STATEMENTS AND SIGN BELOW:

- * I understand payment is expected at each visit and a fee assessment will take place annually to determine if I am eligible for discounted fees. I also understand I may request a new fee assessment at any time throughout the year if changes occur. If I choose not to have a fee assessment done, I understand I will be charged full fee and payment is expected in full at time of service.
- * I understand I am responsible for all charges, including co-payments, deductibles and non-covered services and prompt payment is expected.
- * I understand it is my responsibility to provide my current insurance information and failure to do so may result in claim denial which will then make me responsible for all charges.
- * I understand services provided to me by Planned Parenthood of the Southern Finger lakes and paid for by a third party may appear on a statement of benefits sent to the cardholder.
- * I give permission for any and all information to be released to my insurance company if requested for payment of services.
- * I hereby authorize and direct payment of my medical benefits to Planned Parenthood of the Southern Finger Lakes for services provided.
- * This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____

Patient Print Name: _____

Date: _____