

**PATIENT FINANCIAL FORM**

Patient ID #: \_\_\_\_\_

1. FULL NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Do you live:  Alone or with:  Parents  Spouse  Partner  Children  Roommates  Other: \_\_\_\_\_

3. PLEASE COMPLETE THE APPROPRIATE SET OF QUESTIONS.

**A. FOR HIGH SCHOOL STUDENTS:**

Are your parents supportive of your visit here?  No  Yes If they are, what is your monthly family income? \$ \_\_\_\_\_

How many people does this support? \_\_\_\_\_ Do you have a job?  No  Yes If yes, how much do you earn per week? \$ \_\_\_\_\_

**B. FOR COLLEGE STUDENTS:** Do you live at home or away at school?  Home  School

Do you have a job?  No  Yes If yes, how much do you earn per week? \$ \_\_\_\_\_

How much per week do you have for personal spending? \$ \_\_\_\_\_ (This amount should not include rent, groceries & other regular monthly expenses.)

**C. FOR PATIENTS NOT CURRENTLY IN SCHOOL:** Tell us your GROSS MONTHLY income (gross = before taxes, deductions and expenses).

\$ \_\_\_\_\_ Your employment income

\$ \_\_\_\_\_ Your spouse, partner, or parent's employment income

\$ \_\_\_\_\_ Alimony/child support received (not paid)

\$ \_\_\_\_\_ Other income:  Unemployment  Public Assistance  Disability  Social Security  Other \_\_\_\_\_

\$ \_\_\_\_\_ Regular income and/or interest from trust funds, stock dividends, or other investments

\$ \_\_\_\_\_ **MONTHLY TOTAL** How many people are supported by this income? \_\_\_\_\_

If you have no income, how do you pay for rent, groceries, utilities, & other expenses? \_\_\_\_\_

4. In the past 2 years have you been pregnant and had Medicaid?  No  Yes (If you checked yes, you may be entitled to free services.)

5. PLEASE CHECK OFF THE APPROPRIATE STATEMENT:

I have medical insurance. I understand I need to present my card each time I check in for an appointment. If seeking confidential services, I understand I must sign a Confidentiality Waiver in order for my insurance not to be billed.

**PRIMARY INSURANCE:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Your relationship to the policy holder:  Self  Spouse  Child  Other: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Your relationship to the policy holder:  Self  Spouse  Child  Other: \_\_\_\_\_

I have Medicaid. I understand I need to present my card each time I check in for an appointment or pick up supplies.

I will pay the bill myself. I understand payment is required at the time of visit. I also understand I may be eligible for a discount in fees.

6. PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that I am financially responsible for all charges, including co-payments, deductibles, and/or non-covered services and that prompt payment is expected.
- I understand that 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 they request it for payment of services.
- I hereby authorize payment of all medical/surgical benefits, including major medical benefits to which I am entitled, including private insurance and any other health plans to Planned Parenthood of the Southern Finger Lakes.
- 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: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

For office use only:			
Self Pay Scale: _____	Date ____/____/____	Initials: _____	Comments: _____
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