



**Your Payment Options--please complete only 1 of these 2 options below:**

**Insurance cards must be presented at every visit.**

**Co-payments are due at the time of service. We reserve the right to reschedule if co-pay is not received.**

**1**

**Insurance Company #1:**    **Straight Medicaid**    **Medicaid Managed**    **Other**  
**Is this a work plan?**    **Yes**    **No**

Name of Insurance Company	ID # (Policy #)	Group #	
Address	City	State	Zip
Phone #	Policy Holder's Name	Policy Holder's Date of Birth	

**Insurance Company #2:**    **Straight Medicaid**    **Medicaid Managed**    **Other**  
**Is this a work plan?**    **Yes**    **No**

Name of Insurance Company	ID # (Policy #)	Group #	
Address	City	State	Zip
Phone #	Policy Holder's Name	Policy Holder's Date of Birth	

**OR**

**2**

\_\_\_\_\_ I do not have insurance/Medicaid coverage. I agree to pay Planned Parenthood directly for any services rendered. Same day discounts will be available for certain services. (Please complete "Planned Parenthood Payment Arrangement and Credit Card Form". )

**ALL CLIENTS MUST READ, INITIAL, AND SIGN A, B, & C FOR "GUARANTEE OF BILL PAYMENT"**

A. Planned Parenthood is dedicated to providing health care based upon a patient's ability to pay. I agree to pay Planned Parenthood for services provided to me, and understand that I am entitled to a satisfactory explanation of charges. I understand that I am responsible for any services not covered by my insurance plan or other third party payer. If I am unable to meet this payment requirement, I will advise Planned Parenthood staff and request a payment plan. **TO AVOID USE OF A COLLECTION AGENCY, PLEASE CONTACT OUR BILLING DEPARTMENT IF PAYMENT WILL BE DELAYED.** (Initial here) \_\_\_\_\_

B. I authorize Planned Parenthood to release to my health insurance company, its intermediaries, or carriers any information for this claim or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits directly to Planned Parenthood. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). (Initial here) \_\_\_\_\_

C. My signature below verifies that the information on both sides of this form is accurate to the best of my knowledge.

Signature X \_\_\_\_\_ Date: \_\_\_\_\_