

Client #: _____ **Date:** _____ **Level:** _____

Last Name	First Name	MI	Date of Birth	Age	1st Day of Last Menstrual Period
Address	City	State	Zip	County	

PPSLR may use email or text messaging to contact patients. We will not include any private medical information in our communications. Your email address/text number would only be used to: send appointment reminders (without specifying the reason for the appointment); ask you to check out the PPSLR website to download forms or information; ask you to contact the health center; advise you of political updates affecting our services. Email communication is not necessarily secure or confidential and may be accessed by 3rd parties.

May PPSLR contact you by e-mail? Yes No If yes, email address: _____

May we send you text messages? Yes No

Home Phone #	Work Phone #	Cell Phone #
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EMERGENCY CONTACT: Must be completed for ALL patients. If you are under 18, MUST be a parent.	Name	Relationship	Phone #

LAB TEST RESULTS: PPSLR must be able to contact you if we receive abnormal test results. We also want to protect your privacy. Please identify ways for us to contact you by phone AND by mail.

Phone: Home Phone Yes No Work Phone Yes No Alternate # if "NO" to all _____
 Cell Phone Yes No Leave a message Yes No Whose # is this? _____

Mail: Home Address Yes No Alternate Address must be provided if "NO" is checked:

Whose Address is this? _____

Marital Status: Married Single Divorced Separated Widow	Social Security #:
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How did you hear about us? (circle)

Doctor's office/Insurance company	Print ad (magazine, newspaper, etc.)	Community Event
Radio	Local business/store/restaurant	Internet RHS
Friend/family	Presentation	Phone book Other: _____

Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Multiracial <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Pacific Islander	Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	

Primary Language	Employment Status: Full-Time Part-Time Unemployed
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Highest Grade Completed	Student Status: Full-Time Part-Time Not in School
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STAFF USE ONLY					
DATE	PATIENT INITIALS	STAFF INITIALS	DATE	PATIENT INITIALS	STAFF INITIALS
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Financial Information Form
*****Payment is expected at the time of service*****

Section A: Required for statistical purposes

Do you have private health insurance? Yes No
 If yes, does it cover family planning (birth control) services? Yes No Unknown

Section B: All Patients: please answer either question #1 or #2

1. _____ I prefer to pay at the full rate for services rendered and not declare my income.

2. _____ I choose to declare my income so that I am eligible for a discount.

How many people are supported by this income, including yourself? _____

<p align="center">PATIENT INCOME</p> <p>\$ _____ per hour</p> <p>_____ hours worked per week</p>	<p align="center">SPOUSE/PARTNER/PARENT INCOME <small>(Teens should only indicate parents' income if parents are paying for the visit).</small></p> <p>\$ _____ per hour</p> <p>_____ hours worked per week</p>
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OTHER INCOME (mark all that apply)

Grants Fellowships
 Allowance Other
 Scholarships
 in the amount of \$ _____ per _____

STAFF USE ONLY

Total Weekly Income Entered in EMedsys: _____
 Staff Initials: _____

Section C: Patients who have Medicaid or GHP Insurance

Medicaid	GHP	
Medicaid Number	Name of Insured	Relationship to Patient
Are you on a Medicaid managed care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	SS# of Insured	Date of Birth of Insured
Do you have any other insurance in addition to Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer of Insured	
	Address of Insured (if different from patient's)	

If utilizing Medicaid or GHP insurance, I understand that I am responsible for payment:

- **Of any co-pays or deductibles**
- **For any services provided that Medicaid/GHP does not cover**
- **If I do not have my current Medicaid/GHP card and a picture ID with me**

I certify the above information is accurate and complete. If I am using Medicaid or another insurance, by signing below, I am assigning all benefit payment(s) to PPSLR for services rendered by PPSLR or its contracted vendors.

Client Signature: _____ Date: _____