Planned Parenthood®
of Southwest Missouri

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 #	
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 #:**

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: ☐Caucasian ☐ African American ☐Asian
☐Multiracial ☐Native American/Alaskan Native ☐Pacific Islander

Other: ____________

Hispanic Origin ☐ Yes ☐ No

Primary Language	**Employment Status: Full-Time Part-Time Unemployed**
Highest Grade Completed	**Student Status: Full-Time Part-Time Not in School**

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? _______

PATIENT INCOME

$________ per hour

_______ hours worked per week

SPOUSE/PARTNER/PARENT INCOME
(Teens should only indicate parents' income if parents are paying for the visit).

$________ per hour

_______ hours worked per week

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? ☐ Yes ☐ No	SS# of Insured	Date of Birth of Insured
Do you have any other insurance in addition to Medicaid? ☐ Yes ☐ 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: ________________________