

Tri-Rivers Planned Parenthood® , Inc.
Financial Information

Thank you for choosing Tri-Rivers Planned Parenthood (TRPP) as your health care provider. We are committed to providing the highest quality of care at the lowest possible cost. We require you to read and sign this statement to make sure that you are aware of our payment policies.

- * Payment in full is required at the time of service.
- * Most fees are determined by total household income and how many people are supported by that income.
- * If you refuse to provide us with income information you will be assessed as a full fee patient.
- * Cash, check, money order, and all major credit cards are accepted as payment. We also accept Medicaid and will file with private insurance.
- * Just as you expect TRPP to be honest with you about your health care, we expect you to be honest with TRPP about your financial resources.
- * **Donations to help us keep our doors open are greatly appreciated.**

Do you have private insurance? ___ Yes ___ No (for example, Blue Cross/Blue Shield, United Healthcare, Prudential)
 Does your private insurance cover birth control? ___ Yes ___ No ___ Unknown
 Do you have Medicaid/MC+? ___ Yes ___ No
 Do you want to use your private insurance or Medicaid/MC+ for the services you receive here? ___ Yes ___ No

If yes, we will need to make a copy of any card(s) you have to verify coverage. If coverage is denied, you will be responsible for payment in full. If your insurance company issues you a check after we have filed insurance on your behalf, you will reimburse TRPP for the full amount of the check. By signing this form, you are authorizing us to provide your insurance provider and its agents with any of the information needed to determine benefits payable for services rendered and to receive payment for those services on your behalf. This authorization is effective indefinitely unless you revoke this arrangement.

Are you employed? ___ Yes ___ No Your pay per hour \$ _____ Average number of hours worked per week _____

Circle All Other Sources of Income: Spouse Partner Parents/Guardians Public Assistance Social Security
 Friend Relative Child Support Tips Unemployment Workers Comp Allowance Other _____

Total weekly income from all sources before taxes _____ Number of people supported by this income _____

I hereby certify that the above information is true and accurate to the best of my knowledge. I realize that this information is being given in connection with the receipt of federally subsidized health care. I further realize that deliberate falsification of this information may result in the termination of service.

PATIENT SIGNATURE: _____ DATE: _____

STAFF SIGNATURE: _____ DATE: _____

*****STAFF USE ONLY*****

GROSS INCOME (BEFORE TAXES) WEEKLY: _____	_____ MEDICAID/MC+ (CARD REQUIRED) _____ ME CODE 80	FEE CATEGORY _____
# OF PEOPLE SUPPORTED BY THIS INCOME: _____	_____ INSURANCE (CARD REQUIRED) _____ COPAY AMOUNT	HARDSHIP _____
March 2007	_____ LIMITED ENGLISH PROF.	UNK HOUSEHOLD INCOME AGREES TO PAY AT _____