Planned Parenthood®
Planned Parenthood of the Heartland

## Insurance Information

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|---|---|
| Primary Insurance Company: | Secondary Insurance Company: |
| Policy or Subscriber Number: | Policy or Subscriber Number: |
| Group/Plan Number: | Group/Plan Number: |
| Name of Person with Policy (Policy Holder): | Name of Person with Policy (Policy Holder): |
| Your relationship to the Policy Holder:<br>☐ Self ☐ Spouse ☐ Child ☐ Other | Your relationship to the Policy Holder:<br>☐ Self ☐ Spouse ☐ Child ☐ Other |
| Policy Holder's Employer | Policy Holder's Employer |
| Policy Holder's Date of Birth | Policy Holder's Date of Birth |
| Policy Holder's Address (Street, City, State, Zip): | Policy Holder's Address (Street, City, State, Zip): |
| Prescription (Rx) Insurance Company (If different from Primary Ins. Co.): | Prescription (Rx) Insurance Company (If different from Secondary Ins. Co.): |
| Staff Use Only: Insurance card has been scanned _____ (initial). | Staff Use Only: Insurance card has been scanned _____ (initial). |

I agree to hold PPHeartland, its agents, officers, and employees free and harmless for any actions against it or arising from the disclosure of information described in this *Release and Assignment.* I understand that I have a right to receive a copy of this *Release and Assignment* upon my request and that such copy shall be as effective and valid as the original document.

For any amount received by PPHeartland from a Third Party Payor, PPHeartland will credit my account and I will be solely responsible for any co-payments, deductibles, or co-insurance amounts. PPHeartland will accept payments for covered services received from a Third Party Payor as the full amount, except for such co-payments, deductibles, and co-insurance amounts that are my responsibility. I will be responsible for full payment for any services not covered by a Third Party Payor and which are non-payable or are otherwise excluded.

I give permission for PPHeartland to use an outside lab for the processing of my lab work. I understand it is standard practice for the lab facility to bill my insurance directly. I understand I will be financially responsible for all non-covered lab charges and I will receive a bill directly from the lab facility.

I request that payment of authorized benefits be made on my behalf to PPHeartland. I understand that I am financially responsible for all charges not paid by a Third Party Payor.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Name: _____
Birthdate: _____
PPHeartland Num: _____