



## PATIENT CONTACT AND STATISTICAL INFO

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Chosen Name or Nickname: \_\_\_\_\_ Pronouns: \_\_\_\_\_

*PPSFL will always recognize and use chosen names and pronouns. Please be aware that the name on your insurance must be used on documents pertaining to insurance, billing, and some correspondence.*

Gender: \_\_\_\_\_ Gender, as reflected on your Insurance card: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Address (if different from Mailing Address): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Address mail to:  Legal name  Chosen name/nickname

Email Address: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Okay to say "Planned Parenthood" calling:  Yes  No

Okay to leave a message:  Yes  No

Social Security Number: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Emergency Contact refers to you by your:  Legal name  Chosen name/nickname

Are you a Student?  Yes  No If yes, are you:  Full Time  Part Time

Name of School: \_\_\_\_\_

Person to have on file to pick up supplies (such as birth control pills) for you:

\_\_\_\_\_

### Statistical Information Required by the State of New York:

Do you need an interpreter?  Yes  No

Highest grade of school completed: \_\_\_\_\_ If college/university, number of years attended: \_\_\_\_\_

Marital Status:  Single  Divorced  Married

Separated  Widowed  Living with Partner

Do you have another health care provider (such as a primary care doctor)?  Yes  No

How did you hear about Planned Parenthood's services? (Ex: Radio ad, primary doctor, friend, etc.)

\_\_\_\_\_

Race: \_\_\_\_\_ Are you Hispanic or Latino/a/x?  Yes  No

PATIENT LABEL

## FINANCIAL ASSESSMENT

If you have private insurance, is it okay for Planned Parenthood to bill this insurance?  Yes  No

Age:  Under 18  18 or over

If under 18, are your parents supportive of your visit here?  Yes  No

**Gross Income** (What you are paid before taxes, deductions, and expenses):

If employed, do you work:  Full Time  Part Time  Other # of months/year you work: \_\_\_\_\_

Employer Name #1: \_\_\_\_\_ Average # hours worked per week: \_\_\_\_\_

(Circle) Hourly pay/Annual salary: \$ \_\_\_\_\_

Employer Name #2: \_\_\_\_\_ Average # hours worked per week: \_\_\_\_\_

(Circle) Hourly pay/Annual salary: \$ \_\_\_\_\_

Spouse/Partner Income Amount (monthly): \$ \_\_\_\_\_

How many people supported on all income? \_\_\_\_\_

If **no income** reported, how are you meeting your needs? \_\_\_\_\_

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- I understand payment is expected at each visit and a fee assessment will take place annually to determine if I am eligible for discounted fees. I also understand I may request a new fee assessment at any time throughout the year if changes in my income occur. If I choose not to have a fee assessment done, I understand I will be charged full fee and payment is expected in full at time of service.
  - I understand I am responsible for all charges, including copayments, deductibles, and non-covered services, and prompt payment is expected.
  - I understand it is my responsibility to provide my current insurance information and failure to do so may result in claim denial which will then make me responsible for all charges.
  - I understand services provided to me by Planned Parenthood of the Southern Finger Lakes and paid for by a third party carrier may appear on a statement of benefits sent to the cardholder.
  - I give permission for any and all information to be released to my insurance company if requested for payment of services.
  - I hereby authorize and direct payment of my medical benefits to Planned Parenthood of the Southern Finger Lakes for services provided.
  - **My signature below indicates that the information provided is true and complete and no misrepresentation is being made in order to qualify for discounts to which I would not otherwise be entitled.**
  - This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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