Planned Parenthood
of Greater New York

PATIENT CONTACT AND STATISTICAL INFO

Legal Name: ____ DOB: __________________

Chosen Name or Nickname: __________________________________ Pronouns: _______________

PPGNY 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

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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? _____________________________________

____

- 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 Greater New York 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 Greater New York 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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