

FINANCIAL INFORMATION FORM - Portsmouth City Health Department Family Planning Clinic

Name (Please Print) _____

Social Security #: _____ Date of Birth _____ / _____ / _____
(Optional)

PLEASE COMPLETE ONLY ONE OF THE FOLLOWING BOXES AND SIGN BELOW.

I do not wish to apply for reduced fees at this time. I will pay 100% of my fees with cash, check, credit/debit card or money order.

Your Medicaid or insurance card and picture I.D. MUST be presented at each visit.

I have an Ohio Medicaid card _____

I belong to a Medicaid HMO _____

- Anthem
- Care Source
- Molina

I have Private Medical Insurance with _____ (Insurance Company)

Group ID #: _____

If insurance is not under your name, what is the name and relationship of the person with the insurance?

SS# of the Insured _____ Date of Birth of the Insured _____

Address of the Insured _____

I would like to apply for reduced fees. (Please record all that apply for your household)
 I am 17 years old or younger and need confidential services. Please calculate my fees based on my income only.

Number of people supported by family income (household size)

My hourly wage is \$ _____. I work _____ hours per week.

I live with my spouse/partner/parents who earn \$ _____ per hour. They work _____ hours per week.

I am in College or Vocational School and receive the following funds for my living expenses:

Scholarships/loans \$ _____ Parents \$ _____ Other \$ _____ per quarter semester.

I attend _____ number of quarters/semesters a year

I have the following additional income:

Alimony _____ Unemployment _____ The amount of income is:
 Tips _____ Social Security Other _____ \$ _____ per week month year

I certify the above information is accurate and complete.

Patient Signature: _____

Today's Date: _____ / _____ / _____

For Office Use Only – Required For All Patients

Weekly Income: _____

Fee Category: Full 2 3 4 5 6 Medicaid/Medicaid HMO Private Insurance

Verified By: (staff signature) _____ Today's Date: _____

NO PATIENT WILL BE DENIED SERVICE DUE TO INABILITY TO PAY