Patient Name:_____ MRN:_____ Date:_____

PATIENT FINANCIAL RESPONSIBILITY

Planned Parenthood
Care. No matter what.
Planned Parenthood Keystone
ppkeystone.org • 610.481.0481

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Planned Parenthood. Title X regulations require that clients must not be denied services or be subjected to any variation in quality of services because of the inability to pay. In order to continue providing the quality of care you have come to expect, and to keep our prices reasonable, *you may be asked to pay for today's services*. If you are unable to pay, please let us know. We accept cash and most major credit cards at our office. To pay by credit card, the credit card holder must be present with photo identification.

Program coverage: In accordance with a government program, Planned Parenthood offers qualifying services using a sliding fee scale based on an individual's financial situation. Private insurance and/or medical assistance are billed before the application of any sliding fee discounts.

Insurance: Planned Parenthood Keystone *accepts MOST insurances* (including all Pennsylvania medical assistance plans). It is your responsibility to understand your own plan and financial responsibilities associated with your insurance. If you're unsure about benefits, please call the phone number on the back of your card. You can give them our National Provider Identifier 188 118 4760 or our tax ID 23-2450112. For most insurances, we are considered a specialist provider (OB/GYN). It is also important that you understand your coverage for lab services, which are billed separately (see below).

All financial responsibilities with your insurance are based on your eligibility depending upon medical coverage at the time the services are provided. Verification of your insurance at the time of service is not a guarantee of payment. The services you receive may require co-pays, deductibles and/or coinsurance, which will be collected at the time of service. After billing your insurance, any payment due is payable immediately to Planned Parenthood Keystone.

Out-of-network insurance: If we are out of your insurance network, it is possible we can still bill your insurance, but your financial responsibility may be higher. We may require payment upfront based on discounted rates. If your insurance pays us, we will issue you a refund for any overpayment.

Lab Services: Planned Parenthood uses LabCorp (National Provider Identifier 106 349 7451) and Center for Disease Detection (National Provider Identifier 103 320 3393), a LabCorp affiliated entity, for the processing of lab tests including cytology, pathology, cultures, serum, and STI testing. Please note, your insurance plan may require you use a specific lab for testing.

Billing statements: You may receive a bill from Planned Parenthood Keystone for services not covered under your insurance plan or for services not covered or paid for by other funding sources. If you have confidentiality concerns about receiving a bill, please let us know. You may also receive a separate bill from LabCorp or Center for Disease Detection (CDD) for lab services not covered or paid under your insurance plan.

Refunds: If owed a refund, reimbursements will be processed in one of two ways.
Credit Card: When the original payment was made by credit card, the amount due back to you will be refunded to that card.
Cash or Money Order: If the original payment was made by cash or money order, the amount due back to you will be refunded by check.
It is your responsibility to make sure your contact information on file is up to date.

Assignment of benefits: By my signature below, I authorize assignment of financial benefit directly to Planned

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Parenthood Keystone. I understand that I am financially responsible for charges not covered by this assignment (the patient or patient's guardian, is ultimately responsible for the payment for their treatment and care).

Furthermore, I authorize Planned Parenthood Keystone to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers and/or other physicians or healthcare entities required to participate in my care. The health information I authorize to be released may include any of the following: diagnosis, evaluation, STI/HIV testing results, and/or treatment plans.

By signing below, I am providing written informed consent regarding the preceding documents in which risks, benefits, and alternatives for the services and procedures are explained in detail.

Signature of patient _____

Date _____

I witness that the patient received the above mentioned information, said it was read and understood, and had the opportunity to ask questions.

Signature of witness _____

Date _____

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____

Relationship to patient _____

Date _____

I witness the fact that the patient's legal guardian (or person consenting on the patient's behalf) received the above mentioned information and said it was read and understood.

Signature of witness _____

Date _____