

PLANNED PARENTHOOD OF CONNECTICUT BILLING POLICIES / PATIENT RELEASE & AUTHORIZATION

Please read carefully. If you have any questions, please ask us.

PAYMENT FOR SERVICES: Payment in full is expected at the time of service if you (i) do not have insurance coverage, or (ii) have insurance but choose not to use it. If you use your insurance coverage, co-pays and deductibles are due at the time of service.

SLIDING FEE SCHEDULE: For patients who pay directly and do not have insurance, Planned Parenthood uses a sliding fee schedule ("slide level") based on income, family size, and cost of services for those who apply and qualify. Financial screening is based on the information you provide on the Patient Information Form at the time of your visit.

ACCEPTED METHODS OF PAYMENT: We accept **Cash, Credit Cards (Visa, Mastercard, Discover or American Express), money orders, personal checks and American Express Traveler's Checks.** If you pay by check and the check is returned for insufficient funds, a \$20 "non-sufficient funds" fee will be charged to your account.

HEALTH INSURANCE: **Please be advised that if you use insurance, complete confidentiality of information related to your visit cannot be assured. This is because a statement of your services will normally be sent to the insurance carrier and to the policyholder of your insurance.**

We will ask you for your insurance card each time you visit our office. We depend on you to know and understand your plan's requirements and policies regarding referrals, prior authorizations, co-payments, co-insurance, deductibles, and benefits. Questions about your coverage should be directed to your insurance plan administrator.

Our office will file for payment with selected carriers. We will attempt to resolve any disputes directly with any insurance company for which we are a participating provider. If Planned Parenthood is not a participating provider with your insurance carrier and no payment is received from the carrier within 45 days of our sending them a bill, we will bill you directly at your slide level.

LAB TESTS. If you choose to have Planned Parenthood bill your insurance company and the insurance company refuses to pay for laboratory tests, the laboratory will bill you directly for the uninsured charges. Planned Parenthood is not responsible for these charges. If you are not sure whether your insurance will cover your laboratory charges, you can choose to use Planned Parenthood's contracted laboratory and pay a reduced fee for these services at the time of your visit.

OVERPAYMENTS/REFUNDS/RETURNS: If there is a credit to your account, would you be willing to make this a donation to PPCT instead of receiving a refund? **Yes _____ No _____**

If No, Planned Parenthood will hold your credit for six months, after which time we will attempt to send you a refund for amounts over \$25. If your refund check is returned to Planned Parenthood because you have moved and we do not have your current address, Connecticut state law (C.G.S. Sections 3-65c and 3-66a) requires us to send your credited amount to the State of Connecticut before the end of three years as "abandoned property", in which case, if the amount of your credit is over \$50.00, your name may be published in a newspaper circulated in the county of your last known address.

Patient Authorization of Release of Information for Treatment, Payment and Healthcare Operations - Assignment of Benefits - Financial Responsibility - Overpayment Refund Return Policy	Medicare Authorization of Release of Information for Treatment, Payment & Healthcare Operations Medicare Recipients Must Sign both Authorizations
<p>I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. As part of this authorization, Planned Parenthood of Connecticut (PPCT) will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law.</p> <p>Additionally, I authorize and assign any payment of medical benefits to Planned Parenthood of Connecticut (PPCT), its successors and assigns, or any individual it may designate, for services provided. I understand I am personally responsible to PPCT, its successors and assigns for amounts owed by me in accordance with my health benefit coverage.</p> <p>I acknowledge that I will be responsible for all unpaid claims if I fail to provide my insurance information within the plan's filing limit for services rendered.</p> <p>I understand and agree to PPCT's Overpayments/Refunds>Returns policy described above.</p> <p>I authorize PPCT to bill my credit card for any balance remaining after my insurance has made a payment:</p> <p>_____</p> <p>Credit card number/type good thru</p> <p>_____</p> <p>Patient's Signature Date</p>	<p>I authorize the release of my medical information for purposes of treatment, payment and healthcare operations.</p> <p>I request that payment of authorized Medicare benefits be made either to me or on my behalf to PPCT for services furnished to me by the providers.</p> <p>I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the payable benefits for related services rendered and performed.</p> <hr style="border: 1px solid black;"/> <p style="text-align: center;">Patient's Signature Date</p>

Planned Parenthood of CT

Patient Contact Information

Today's Date: _____

Last Name:		First Name:		Middle Initial:	<input type="checkbox"/> Jr <input type="checkbox"/> Other _____
Maiden or Nick Name:		Social Security #	-- --	Date of Birth	Age
Street Address:		Apt:	P.O Box:	City:	State: Zip:
*Home Phone:()		*Work Phone:()		*Cell Phone:()	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Biological Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Place of Employment:		Employer's Address:			
E-mail (optional):					

Patient Contact Information: We may contact you regarding any testing and medical care that you receive at Planned Parenthood, as well as about any outstanding account balances. It is important that we are able to reach you. If we need to contact you and we cannot reach you at home or at work, we will use your emergency contact information. You may also provide an alternative contact.

**Please be aware that if you do not accept blocked calls, Planned Parenthood's name and phone number will appear on your screen.*

If we call you at home, work, or on your cell phone, may we say, "Planned Parenthood is calling"?

(Telephone Number)

HOME# Yes _____ Please say "The doctor's office is calling." No If "no", what code name can we use? _____

CELL# Yes _____ Please say "The doctor's office is calling." No If "no", what code name can we use? _____

WORK# Yes _____ Please say "The doctor's office is calling." No If "no", what code name can we use? _____

If we send mail to your home, can Planned Parenthood be identified on the envelope?

Yes Street/PO Box Address Only

Alternate Contact: If we cannot send you a letter at home, where can we send it and to whom should we address it?

Emergency Contact Information: (We must have an emergency contact for each patient)

Name: _____ Phone Number: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ Zip _____

How do you plan to pay for your visit today?

I have insurance that will cover my visit. I do not have insurance and will pay the bill myself.

If you are covered by one or more insurance policies, please provide the following information and give the receptionist your insurance card(s) to copy.

Primary Insurance Company Name: _____ **Personal ID No:** _____ **Group ID No:** _____

If your Primary Insurance coverage comes from someone else's policy, please complete below:

Whose insurance is it? Mother Father Spouse Guardian Other _____

Insured Person's Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____ Social Security #: _____ - _____ - _____

Place of Employment: _____ Employer's Address _____

Secondary Insurance Company Name: _____ **Personal ID No:** _____ **Group ID No:** _____

If your Secondary Insurance coverage comes from someone else's policy, please complete below:

Whose insurance is it? Mother Father Spouse Guardian Other _____

Insured Person's Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____ Social Security #: _____ - _____ - _____

Place of Employment: _____ Employer's Address _____

Date(s) this form last updated by patient: _____