

MyAlly Health

Legal Full Name _____ Former/Maiden Name _____

Name You Use (optional) _____ Date of Birth _____

Sex Assigned at Birth? ☐ Female ☐ Male Gender Identity _____ Pronoun(s) _____

Mailing Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Can we enroll you in our patient portal? ☐ Yes ☐ No Would you like to receive informational emails? ☐ Yes ☐ No

How can we reach you? (We may need to follow-up with you after your visit for billing or healthcare purposes. Please provide the contact information you agree to let us use for these purposes. By providing your contact information, you imply consent for us to call you if necessary. If you have privacy concerns, please inform the front desk. Circle all that apply.) **EMAIL MAIL PORTAL TEXT VOICEMAIL**

Marital Status (check one)? ☐ Living Together ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you Hispanic or Latino? ☐ Yes ☐ No

Race (check all that apply):

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Pacific Islander/Hawaiian ☐ White ☐ Decline to Specify

Primary Language? _____

EMERGENCY CONTACT Please tell us who to contact in case of emergency (trusted adult if under 18). An emergency would be severe bleeding, unconsciousness, accident or a condition requiring emergency intervention. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a trusted adult.

Name _____ Relationship to You _____ Phone _____

AUTHORIZED PERSONS Your privacy is important to us. If anyone will be calling on your behalf for any reason, or picking up supplies for you, we will need your consent to speak with them. You can contact us at any time to update this information.

Name _____ Relationship to You _____

Please check if you have any of the following: ☐ MEDICAID (TRADITIONAL) ☐ MEDICAID (EXPANSION)
☐ PRIVATE HEALTH INSURANCE ☐ GOVERNMENT INSURANCE (MILITARY, VA) ☐ MEDICARE ☐ WOMEN'S WAY ☐ NONE

May we submit to insurance? ☐ Yes ☐ No If no, is there a reason that you do not want insurance billed? _____

If you marked YES, please complete the following:

Name of Primary Insurance _____ Policy Number _____

Name of Policy Holder _____ Relationship to Policy Holder _____ Policy Holder Date of Birth _____

You should know that private insurance companies send out a letter called an explanation of benefits (EOB) to the insurance policy holder about the healthcare services you receive. If you are 18 years old or older, you may contact your insurance company to request that EOBs be sent to you instead of the policy holder to protect your privacy.

FINANCIAL RESPONSIBILITY CONSENT I voluntarily request services from MyAlly Health and accept full financial responsibility for any costs after insurance and applicable discounts. I understand that I may get a bill. I understand that I may set up a payment plan. Amounts with no payments for over 90 days may be released to an outside collection agency with reporting to credit bureaus. Essential services will not be denied for inability to pay. If providing insurance, I authorize MyAlly Health to release any information necessary to process my claims to be paid directly to MyAlly Health. I have not given false information nor withheld information. The answers to the above questions are true and complete to the best of my knowledge.

Signature _____ Today's Date _____

FILL OUT BACK OF PAGE



Sliding Fee Scale Discounts

Part of our mission is to provide accessible, quality reproductive and sexual health services to all who need them, regardless of insurance or citizenship status. The information we request helps us demonstrate whether we are adequately serving our community, and so that we can continue to receive the grants that make our services possible. The Family Planning Program operates under a sliding fee scale which will determine the fees that are applied to these services. Please fill in the following information to determine if discounts are available to you. It is federally required by the program to collect this data. Your financial information is protected and will not be shared. Please note: some services are not eligible for discounts.

Household Size and Income Information:

Household Size: _____ (Number of individuals supported by the family income. Include yourself, dependents, and partners with shared finances.)

How many months of the year are you expecting to work? _____ /12

Your Income: (If you are a minor who wishes to receive services without parental consent, charges are based on only your income. If your parents are aware that you are receiving services, charges will be based on your household income – see below.)

_____ hours weekly at \$ _____ /per hour – **OR** – \$ _____ yearly before taxes

_____ hours weekly at \$ _____ /per hour – **OR** – \$ _____ yearly before taxes

Household Income (Partner/Spouse/Parents):

_____ hours weekly at \$ _____ /per hour – **OR** – \$ _____ yearly before taxes

_____ hours weekly at \$ _____ /per hour – **OR** – \$ _____ yearly before taxes

Other Income or Financial Support

Tips or Commission \$ _____ per week

Regular Family Support (support by someone not living in the household) \$ _____ per month

Grants or Stipends (the amounts used towards living expenses) \$ _____ per month

Unemployment \$ _____ per month

Alimony \$ _____ per month

Income from an owned rental property (NOT amount paid for rent) \$ _____ per month

Miscellaneous Income: Gifts over \$15,000, capital gains, training stipends or union strike benefits, private pensions, regular insurance/annuity payments, dividend income, interest rent/royalties, food/rent instead of wages, assets drawn as bank withdrawals, proceeds from the sale of house/car/property, periodic receipts from estates or trusts.

\$ _____ per _____ Notes _____

TO OPT-OUT OF DISCOUNTS – REVIEW AND SIGN THE STATEMENT BELOW:

I would not like to disclose my household size and/or income information. I understand that by choosing to opt-out I will not be eligible for discounts on my services today, and I will be charged at the full fee. I understand that after I leave the clinic, I cannot apply for discounts for services that have already been provided.

Signature _____ Today's Date _____

MYALLY HEALTH STAFF USE ONLY:

Chart Number:	Household Size:	Total Income:	Discount Scale: 0% 25% 50% 75% 100%	Staff Initials:	Is Client Requesting Enhanced Confidential Services: YES NO
------------------	--------------------	---------------	---	-----------------	---