

## STATEMENT OF FINANCIAL CONDITION

|                    |                       |
|--------------------|-----------------------|
| PATIENT NAME _____ | SPOUSE _____          |
| ADDRESS _____      | PHONE _____           |
| ACCOUNT # _____    | SSN _____             |
|                    | (PATIENT)<br>(SPOUSE) |

FAMILY STATUS: List all dependents that you support

| Name  | Age   | Relationship |
|-------|-------|--------------|
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |

### EMPLOYMENT AND OCCUPATION

Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
 Contact Person & Telephone: \_\_\_\_\_  
 If Self-Employed, Name of Business: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
 Contact Person & Telephone: \_\_\_\_\_  
 If Self-Employed, Name of Business: \_\_\_\_\_

### CURRENT MONTHLY INCOME

|                  |  | Patient | Spouse |
|------------------|--|---------|--------|
|                  | Gross Pay (before deductions)  |         |        |
| <i>Add:</i>      | Income from Operating Business (if Self-Employed)                        | _____   | _____  |
| <i>Add:</i>      | Other Income:  |         |        |
|                  | Interest and Dividends   | _____   | _____  |
|                  | From Real Estate or Personal Property                                    | _____   | _____  |
|                  | Social Security  | _____   | _____  |
|                  | Other (specify):   | _____   | _____  |
|                  | Alimony or Support Payments Received                                     | _____   | _____  |
| <i>Subtract:</i> | Alimony, Support Payments Paid   | _____   | _____  |
| <i>Equals:</i>   | Current Monthly Income   | _____   | _____  |
|                  | Total Current Monthly Income (add Patient + Spouse<br>Income from above) | _____   | _____  |

### FAMILY SIZE

Total Family Members  
 (add patient, spouse and dependents from above) \_\_\_\_\_

- |  |  |  |
|--|--|--|
| Do you have Health Insurance?  |  | Yes<br>No<br><input type="checkbox"/>                |
| Do you have other Insurance that may apply (such as an auto policy)?                         |  | <input type="checkbox"/>                             |
| Were your injuries caused by a third party (such as during a car accident or slip and fall)? |  | <input type="checkbox"/><br><input type="checkbox"/> |

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financing discount. I understand that I may be required to provide proof of the information I am providing.

\_\_\_\_\_

(Signature of Patient or Guarantor)

\_\_\_\_\_

(Date)

\_\_\_\_\_

(Signature of Spouse)

\_\_\_\_\_

Attachment A  
Policy 14-294