

## STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____	SPOUSE _____
ADDRESS _____	PHONE _____
ACCOUNT # _____	SSN _____
	(PATIENT) (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
<i>Add:</i> 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 Income from above)	_____	_____

### FAMILY SIZE

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

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