

Financial Statement

If you have not yet discussed your financial situation with Patient Financial Services, please do so **PRIOR** to completing this form. This information will help us assess your financial situation and determine your ability to pay for services provided by Mayo Clinic and our affiliates. Note that until your financial statement has been reviewed and approved by our financial counselors, you will be financially responsible for your medical care.

In addition to the completed financial statement, you may also be asked by a financial counselor to supply the following:

- Income tax returns, W-2 forms
- Explanations of Benefits (EOBs)
- Copies of pay stubs
- Social Security Benefit Statement.
- Copies of other medical, dental, or pharmacy bills
- Copies of bank statements from checking and savings accounts

General information

Patient _____
 Patient Registration # _____
 Phone Number _____
 Social Security # _____
 Address _____

How many times have you been to one of our facilities as a patient? _____

Have you ever received financial assistance for a visit to one of our facilities? Explain: _____

Are you a full-time student? _____ Are you a part-time student? _____ School _____

Spouse/Responsible Party

Name _____
 Registration # _____
 Phone Number _____
 Social Security # _____

Responsible Party (If under 18, complete for both parents)

Name _____
 Registration # _____
 Phone Number _____
 Social Security # _____

Employer Information

Employer _____
 Employer Address _____
 Phone Number _____
 Job Title _____
 Length of Employment _____

Employer _____
 Employer Address _____
 Phone Number _____
 Job Title _____
 Length of Employment _____

Dependents

Name	Age	Registration #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Bank

Bank Name _____
 Bank Address _____
 Checking Acct # _____
 Balance \$ _____
 Savings Acct # _____
 Balance \$ _____
 Other Investments and Securities _____

Property

	<u>Estimated Value</u>	<u>Unpaid Balance</u>
Residence: Own _____ Rent _____		
Monthly Payments \$ _____		
Residence _____	\$ _____	\$ _____
Vehicles _____		
Year/Make _____	\$ _____	\$ _____
Year/Make _____	\$ _____	\$ _____
Land: # of acres _____	\$ _____	\$ _____
Business _____	\$ _____	\$ _____
Rental Property _____	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____

Monthly Income

	<u>Source</u>	<u>Monthly Income</u>	
1. Patient/Parent if under 18	_____	\$ _____	1.
2. Spouse/Responsible Party	_____	\$ _____	2.
3. Interest/Dividends	_____	\$ _____	3.
4. Pension/Disability	_____	\$ _____	4.
5. Child Support/Alimony	_____	\$ _____	5.
6. Other	_____	\$ _____	6.
7. Total Gross Monthly Income		\$ _____	7.
8. FICA + Income Taxes Withheld		\$ _____	8.
9. Net Monthly Income		\$ _____	9.

Monthly Expenses

	<u>Average Monthly Expense</u>	
10. Groceries.....	\$ _____	10.
11. Utilities.....	\$ _____	11.
12. Auto (Gas, Repairs).....	\$ _____	12.
13. Telephone.....	\$ _____	13.
14. Cable.....	\$ _____	14.
15. Entertainment.....	\$ _____	15.
16. Clothing.....	\$ _____	16.
17. Child Care.....	\$ _____	17.
18. Child Support/Alimony.....	\$ _____	18.
19. Medications.....	\$ _____	19.
20. Other.....	\$ _____	20.

Creditors

Please indicate all other monthly payments, e.g. bank payments, credit cards, other medical, etc.

	<u>To Whom</u>	<u>Unpaid Balance</u>	<u>Monthly Payment</u>	
21. Rent/Mortgage	_____	\$ _____	\$ _____	21.
Original Principal Amount: \$ _____				
22. Medical: Doctor	_____	\$ _____	\$ _____	22.
23. Medical: Hospital	_____	\$ _____	\$ _____	23.
24. Credit Card	_____	\$ _____	\$ _____	24.
25. Credit Card	_____	\$ _____	\$ _____	25.
26. Home Equity Loan	_____	\$ _____	\$ _____	26.
27. Other	_____	\$ _____	\$ _____	27.
28. Other	_____	\$ _____	\$ _____	28.
Insurance		<u>Annual Premium</u>	<u>Monthly Payment</u>	
29. Auto	_____	\$ _____	\$ _____	29.
30. Life	_____	\$ _____	\$ _____	30.
31. Health	_____	\$ _____	\$ _____	31.
32. Other	_____	\$ _____	\$ _____	32.
33. TOTAL MONTHLY EXPENSES (add lines 10 through 32)			\$ _____	33.
34. INCOME LESS EXPENSES (line 9 minus 33)			\$ _____	34.

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Mayo Clinic and its affiliates. I hereby grant permission to Mayo Clinic, its affiliates and representatives to investigate the information contained herein, and to obtain a credit report.

SIGNATURE _____ DATE: _____