



Instructions

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 will also be asked by a financial counselor to supply the following:

- Income tax returns, W-2 forms (previous 2 years)
Copies of recent pay stubs
Social Security Benefit Statement (if applicable)
Copies of bank checking and savings accounts statements

General Information

Spouse/Responsible Party

Patient
Patient Registration Number
Phone Number
Social Security Number
Address

Name
Registration Number
Phone Number
Social Security Number
Responsible Party (if under 18, complete for both parents)
Name
Registration Number
Phone Number
Social Security Number

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:

Employer Information - Patient

Employer Information - Spouse/Responsible Party

Employer
Employer Address
Phone Number
Job Title
Length of Employment

Employer
Employer Address
Phone Number
Job Title
Length of Employment

Dependents

Bank

Name Age Registration Number

Bank Name
Bank Address
Checking Account Number Balance
Savings Account Number Balance
Other Investments and Securities

Property

Table with 3 columns: Description, Estimated Value, Unpaid Balance. Rows include Residence (Own/Rent), Vehicles, Land, Business, Rental Property, and Other.

Monthly Income

	Source	Monthly Income	
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 Expense

	Average Monthly Expense	
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.

	To Whom	Unpaid Balance	Monthly Payment	
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		Annual Premium	Monthly Payment	
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.

Certification

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 _____