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
	Gross Pay (before deductions)		
Add:	Income from Operating Business (if Self-Employed)		
Add:	Other Income:		
	Interest and Dividends		
	From Real Estate or Personal Property		
	Social Security		
	Other (specify):		
	Alimony or Support Payments Received		
Subtract:	Alimony, Support Payments Paid		
Equals:	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) _____

	Yes	No
Do you have Health Insurance?	☐	☐
Do you have other Insurance that may apply (such as an auto policy)?	☐	☐
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	☐	☐

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