Riveredge Hospital

RETURN TO: _____

REVIEWED BY: _____

DATE SENT: _____

DATE REVIEWED: _____

FINANCIAL DISCLOSURE FORM

TO BE COMPLETED BY PERSON RESPONSIBLE FOR BILL

The information requested is to allow us to assist you in establishing a reasonable payment program and is confidential. You must provide us with complete information to enable us to determine how wer can help you.

PATIENT:

1. Name: _____ SSN: _____ Patient No.: _____

2. Address: _____ Admin. Date: _____
   Street City State Zip

3. Name: _____ SSN: _____
   Last First Middle Driver (DL#)

   License #: _____

4. Address: _____ Phone: _____
   Street City State Zip

5. Employment: _____ Phone: _____
   Employer

   _____ How Long?: _____
   Street City State Zip

6. Are you disabled?: _____ If yes, disability: _____

DEPENDENTS (OF RESPONSIBLE PARTY):

SPOUSE:

7. Name: _____ SSN: _____
   Last First Middle

8. Address: _____ Phone: _____
   Street City State Zip

9. Employment: _____ Phone: _____
   Employer

   _____ How Long?: _____
   Street City State Zip

10. Are you disabled?: _____ If yes, disability: _____

DEPENDENTS OTHER THAN SPOUSE FOR WHICH YOU PROVIDE FOOD AND SHELTER:

11. Ages: _____

12. Are any of the above dependents employed?: _____ Where?: _____

13. Are any of the above dependents disabled?: _____ Disability: _____

14. Which of the above dependents do not live with you?: _____

15. Why?: _____

INSURANCE:

16. Is the above patient covered by any health insurance through an employer or private ☐ Yes ☐ No

If yes, name of primary insurance: _____

Benefits coverage: _____

Name of secondary insurance: _____

Benefits coverage: _____

RESPONSIBLE PARTIES FINANCIAL INFORMATION

17. PRESENT EMPLOYER(S) ALL SOURCES	OCCUPATION	WORK PHONE	MONTHLY GROSS PAY	MONTHLY TAKE HOME	YEARS ON JOB
a.					
b.					
c.					
d.					

18. ANY OTHER SOURCE OF INCOME: _____ MONTHLY AMOUNT: _____

_____ TOTAL MONTHLY INCOME: _____
(TAKE HOME)

19. PLEASE LIST AVAILABLE ASSETS:
CARS $_____
HOMES $_____
SAVINGS $_____
OTHER $_____
OTHER $_____

20. CHECKING $_____
STOCKS/BONDS $_____
LIFE INS. $_____
REAL ESTATE $_____
$_____

21. MONTHLY EXPENSES	MONTHLY PAYMENT	BALANCE	COMMENTS/PURPOSE
a) Food	$ _____	$ _____	_____
b) Gas Heat	$ _____	$ _____	_____
c) Electric	$ _____	$ _____	_____
d) Water	$ _____	$ _____	_____
e) Telephone	$ _____	$ _____	_____
f) Transportation/Gasoline	$ _____	$ _____	_____
g) Rent/Mortgage Payment	$ _____	$ _____	_____
h) Second Mortgage	$ _____	$ _____	_____
i) Alimony, Child Support	$ _____	$ _____	_____
j) Auto 1	$ _____	$ _____	_____
k) Auto 2	$ _____	$ _____	_____
l) Car Insurance	$ _____	$ _____	_____
m) Life Insurance	$ _____	$ _____	_____
n) Health Insurance	$ _____	$ _____	_____
o) Credit Card 1	$ _____	$ _____	_____
p) Credit Card 2	$ _____	$ _____	_____
q) Credit Card 3	$ _____	$ _____	_____
r) Bank Loan 1	$ _____	$ _____	_____
s) Bank Loan 2	$ _____	$ _____	_____
t) Finance Co. 1	$ _____	$ _____	_____
u) Finance Co. 2	$ _____	$ _____	_____
v) Other	$ _____	$ _____	_____
w) Other	$ _____	$ _____	_____

TOTAL MONTHLY EXPENSES $ _____

22. REASON FOR REQUEST TO DISCOUNT OR WAIVE DEDUCTIBLE OR CO-PAY AMOUNTS: _____
_____

23. PLEASE LIST ANY OTHER FINANCIAL CONDITIONS WHICH SHOULD BE CONSIDERED IN ESTABLISHING A PLAN: _____
_____
_____

I hereby authorize representative of RIVEREDGE HOSPITAL to make whatever inquiries necessary to verify the information furnished on this form, or to release any information regarding this hospitalization on any insurance company or third party to seek settlement of this amount. I hereby state that to the best of my knowledge the information given above is true and complete. I further authorize REH to review and/or inquire into my credit history using any means available to obtain a current Credit Bureau History Report.

24. _____ SIGNATURE _____
Date

25. _____ 26. SPOUSE _____
Witness Date