

STATEMENT OF FINANCIAL CONDITION (Attachment A)

PATIENT NAME _____ SPOUSE _____

ADDRESS _____ PHONE _____

ACCOUNT # _____ SSN: _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents 18 years of age or under, full time student, or disabled. Proof of student or disability may be required.

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer (or business name): _____ Position: _____

Contact Person & Telephone: _____

Spouse Employer: _____ Position: _____

Contact Person & Telephone: _____

CURRENT MONTHLY INCOME

Start: 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: Total Current Monthly Income (add Patient+Spouse Income from above) _____

FAMILY SIZE

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

This institution is an equal opportunity provider

By signing this form, I agree to allow South Lyon Medical Center and its representatives to check employment and credit history for the purpose of determining

my eligibility for a financial 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) (Date)