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

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

This form and all requested information should be returned within 10 business days.

General information

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

Spouse/Responsible Party

Name _____
Phone Number _____
Social Security # _____

Responsible Party (If under 18, complete for both parents)
Name _____
Phone Number _____
Social Security # _____

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

Employer Information - Spouse

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

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

Monthly Income	Source	Monthly Income	
1. Household Income	_____	$ _____	1.
2. Interest/Dividends	_____	$ _____	2.
3. Pension/Disability	_____	$ _____	3.
4. Child Support/Alimony	_____	$ _____	4.
5. Other	_____	$ _____	5.
6. Total Gross Monthly Income		$ _____	6.

Creditors

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

	To Whom	Unpaid Balance	Monthly Payment	
7. Rent/Mortgage				
Original Principal Amount: $_____	_____	$ _____	$ _____	7.
8. Medical: Doctor	_____	$ _____	$ _____	8.
9. Medical: Hospital	_____	$ _____	$ _____	9.
10. Credit Card	_____	$ _____	$ _____	10.
11. Credit Card	_____	$ _____	$ _____	11.
12. Home Equity Loan	_____	$ _____	$ _____	12.
13. Other	_____	$ _____	$_____	13.
14. Other	_____	$ _____	$_____	14.

Insurance		Annual Premium	Monthly Payment	
15. Auto	_____	$ _____	$ _____	15.
16. Life	_____	$ _____	$ _____	16.
17. Health	_____	$ _____	$ _____	17.
18. Other	_____	$ _____	$ _____	18.

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: _____

Please return to:
Mayo Clinic
Attn: Charity Care Inquiries
4500 San Pablo Road
Jacksonville, FL 32224