

**SURGERY CENTER CEDAR RAPIDS
FINANCIAL CONSIDERATION APPLICATION**

PATIENT (RESPONSIBLE PARTY) INFORMATION:

Name _____

Date of Birth _____

Address _____

Social Security # _____

City _____

Employer _____

State _____ Zip _____

Employer Address _____

Phone (_____) _____

Employer Phone# (_____) _____

Cell Phone _____

Length of Time at Employment _____

SPOUSE INFORMATION:

Spouse Name _____

Spouse SSN # _____

Address (if different from above) _____

Employer _____

Employer Address _____

Phone (if different from above)

(_____) _____

Employer Phone (_____) _____

FINANCIAL INFORMATION:

Patient's(RP) Monthly Income Before Taxes _____

Spouse's Monthly Income Before Taxes _____

If Unemployed, Weekly Unemployment _____

of Weeks Unemployed _____

Secondary or Part-Time Jobs Weekly Income _____

Social Security (Monthly) _____

Pensions (Monthly) _____

Annuities (Monthly) _____

Savings Account Balances _____

IRA Balances _____

Stocks or Bonds Cash Value _____

Family size you are responsible for: _____

Adults _____

Children _____

Do you pay any child support? If yes, how much per year? _____

How are you planning to resolve the balance on your account? _____

A copy of last year's tax return is required for validation.

I declare under penalty of perjury under the laws of the state of Iowa that the above is true and correct and I further understand substantial consequences can result from providing false information.

Preparer's Signature

Date