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