

St♥Mary's HOSPITAL

707 South Mills Street
Madison, WI 53715-0450

FINANCIAL STATEMENT

Patient Information:

Patient Name (Last, First,MI): _____

Date of Birth (mm/dd/yy): _____ Social Security # _____

Street Address _____

City, State _____ Zip Code: _____

Account #: _____

Dates of Service: _____

Others Residing in Household:

Name (Last, First/Relationship to patient) _____ Date of Birth (mm/dd/yy) _____

_____	_____
_____	_____
_____	_____
_____	_____

Employment Information:

Name _____ Monthly Gross Salary _____

Employment Status: Employed Retired Unemployed Other _____

Employer: _____ Occupation _____

Length of Employment _____ Employer Phone# _____

Circle your Household Income Level for the Past 12 Months:

\$0 - \$9,999	\$10,000 - \$14,999	\$15,000 - \$19,999
\$20,000 - \$24,999	\$25,000 - \$29,999	\$30,000 - \$39,999
\$40,000 - \$49,999	\$50,000+	

Additional Source of Income:

Spouse	\$ _____	Worker's Compensation	\$ _____
Rental Income	\$ _____	Unemployment	\$ _____
Food Stamps	\$ _____	Sick Pay	\$ _____
Pension	\$ _____	Social Security	\$ _____
SSI/SSD	\$ _____	Other Income	\$ _____

No Source of Income, how have you been supporting yourself? _____

Assets:

Account	Name of Bank/S&L/Loan Co.	Current Balance
Checking		
Savings		
Life Insurance (cash value)		
401-K, IRA, TSA and other retirement plan		
Stocks/Bonds (cash value)		
CD's		
Property other than Home (land, rental property, etc)		
Cash on Hand		
Other		

Monthly Expenses:

Expense:	Outstanding balance	Monthly Payment
Rent or Mortgage		
Gas/Oil/Wood		
Electric		
Water/Sewer		
Phone		
Child Care		
Support Payments		
Charge Cards		
Car Loan		
Equity Loan		
Medical (not covered by ins)		
Dental (not covered by ins)		
Food		
Clothing		
Other (cable, insurance, etc)		
Total Monthly Expenses		

Other Information you would like to include:

Please list other agencies you have contacted for assistance:

Authorization for Representation:

I, the undersigned, hereby authorize St. Mary's Hospital to discuss the specifics of my medical and financial file in their efforts to research financial resources on my behalf.

Authorization for Release of Information:

This authorization includes the release to St. Mary's Hospital of any financial statements, business reports, payroll or benefit information from my past or present employers, assessments or evaluations.

I understand written notification is required by me to revoke this authorization. I also understand that a photocopy of this authorization has the same effect as the original.

Patient or Responsible Party Signature: _____
Relationship: _____ Date: _____

Please return signed and completed form within 10 days to St. Mary's Business Office in the enclosed postage paid envelope.