HALIFAX HEALTH
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
1041 Dunlawton Ave., Port Orange, FL 32127

Patient Name
Adm. Date Dr.
Date of Birth Age
MR # Visit #

FINANCIAL STATEMENT

PATIENT NAME: _____ D.O.B.: _____SS #: _____

ADDRESS: _____ PHONE:(_____) _____

EMPLOYER: _____ PHONE:(_____) _____

SELF EMPLOYED (check one): ❑ YES ❑ NO

GROSS ANNUAL BUSINESS INCOME (if self employed): $ _____

NET ANNUAL BUSINESS INCOME: $ _____

NEAREST RELATIVE: _____ PHONE:(_____) _____

TOTAL IN HOUSEHOLD: _____ TOTAL DEPENDENTS:_____

GROSS ANNUAL PERSONAL INCOME
(Please include a copy of your most recent W2 tax form for all employment): $ _____

*CURRENT GROSS MONTHLY INCOME (Please include a copy of your most recent pay stub): $ _____

TOTAL NET MONTHLY INCOME: $ _____

BANK NAME: _____

CHECKING ACCOUNT BALANCE: $ _____ SAVINGS ACCOUNT BALANCE: $ _____

*** * A complete bank statement of all checking, savings, and/or inrvestment account(s) with transaction detail(s) MUST be provided with this Financial Statement in order to be considered for review.**

OTHER ASSETS / INCOME: $ _____ (Income type: weekly, monthly, quarterly, bi-annual, annual)
(e.g. stocks, bonds, 401K, rental income/properties, etc.)

PLEASE LIST THE TYPE OF OTHER ASSETS / INCOME:_____

_____

COMMENTS: _____

_____

ON THE FOLLOWING PAGE PLEASE LIST YOUR MONTHLY PAYMENT(S) AND BALANCE(S) DUE FOR THE EXPENSES LISTED:

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FINANCIAL STATEMENT

(continued)

MONTHLY EXPENSES:	**PAYMENT:**	**BALANCE DUE:**
RENT / MORTGAGE: (circle one)	$ _____	$ _____
AUTOMOBILE: (if leased or financed)	$ _____	$ _____
UTILITIES:	$ _____	$ _____
LOANS:	$ _____	$ _____
CREDIT CARDS:	$ _____	$ _____
INSURANCE: (car / home)	$ _____	$ _____
CHILD SUPPORT / ALIMONY:	$ _____	$ _____
CHILD CARE:	$ _____	$ _____
FOOD:	$ _____	$ _____
CLOTHING:	$ _____	$ _____
TRANSPORTATION:	$ _____	$ _____
OTHER MEDICAL:	$ _____	$ _____
OTHER:	$ _____	$ _____
TOTAL MONTHLY EXPENSES:	$ _____	$ _____

*** * Please provide copies of all statements, bills, and/or proof of payment for the debts listed above (e.g. cancelled checks, money orders, banking statements, current account statements reflecting payments and balances outstanding, utility bills, etc.) Failure to return all supporting documentation will exclude this document from being reviewed.**

STATEMENT AND FINAL CLEARANCE

I, the undersigned, being responsible for the named applicant, do hereby swear that the information contained herein is true and correct. I hereby swear that I am unable to pay the entire amount of my medical bills in one payment, and am requesting monthly installment payments be made until the account is paid in full. Therefore, I grant permission and authorize any bank, building association, insurance company, real estate company, financial institution, and credit grantors of any kind or character to disclose to any authorized agent of Halifax Health of Daytona Beach, Florida, information as to my past and present bank accounts, insurance policies, property, credit experience, credit application and all pertinent information related thereto. I authorize this information to be made available to all providers who participate in the Halifax Health program, should I be accepted. I understand that providing false information to defraud a hospital to obtain goods or services is a second degree misdemeanor and punishable under the FL Statute 817.50. VIOLATORS WILL BE PROSECUTED.

_____	_____
DATE	DATE
_____	_____
PRINT NAME	WITNESS - PRINT NAME
_____	_____
SIGNATURE	WITNESS - SIGNATURE

N-HMC - 465 - 9/08