Streamwood Behavioral Health Center

FINANCIAL DISCLOSURE FORM

RETURN TO: ____________________

REVIEWED BY: ____________________

DATE SENT: ____________________

DATE REVIEWED: ____________________

TO BE COMPLETED BY PERSON RESPONSIBLE FOR BILL

The information requested is to allow us to assist you in establishing a reasonable payment program and is confidential. You must provide us with complete information to enable us to determine how we can help you.

PATIENT:

1. Name: ____________________ SSN: ____________ Pat No.: ____________

2. Address: ________________________________ Admin. Date: __________
Street City State Zip

RESPONSIBLE PARTY:

3. Name: ________________________________ SSN: ____________
Last First Middle
Driver (DL#) License # __________

4. Address: ________________________________ Phone: ____________
Street City State Zip

5. Employment: ________________________________ Phone: ____________
Employer

________________________________ How Long?: _____
Street City State Zip

6. Are you disabled? _______ If yes, disability: ____________________

DEPENDENTS (OF RESPONSIBLE PARTY):

SPOUSE:

7. Name: ________________________________ SSN: ____________
Last First Middle

8. Address: ________________________________ Phone: ____________
Street City State Zip

9. Employment: ________________________________ Phone: ____________
Employer

________________________________ How Long?: _____
Street City State Zip

10. Is your spouse disabled? _______ If yes, disability: ____________________

DEPENDENTS OTHER THAN SPOUSE FOR WHICH YOU PROVIDE FOOD AND SHELTER:

11. Ages: ________________________________

12. Are any of the above dependents employed? ______ Where: ____________________

13. Are any of the above dependents disabled? ______ Disability: ____________________

14: Which of the above dependents do not live with you? ____________________

15. Why? ________________________________

INSURANCE:

16. Is the above patient covered by any health insurance through an employer or private plan? ☐ Yes ☐ No

If yes, name of primary insurance: ____________________

Benefits coverage: ____________________

Name of secondary insurance: ____________________

Benefits coverage: ____________________

RESPONSIBLE PARTIES FINANCIAL INFORMATION

17. PRESENT EMPLOYER(S) ALL SOURCES	OCCUPATION	WORK PHONE	MONTHLY GROSS PAY	MONTHLY TAKE HOME	YEARS ON JOB
a.					
b.					
c.					
d.					

18. ANY OTHER SOURCE OF INCOME: ____________________ MONTHLY AMOUNT: __________

____________________ TOTAL MONTHLY INCOME: __________
(TAKE HOME)

19. PLEASE LIST AVAILABLE ASSETS:

CARS $ ____________
HOMES $ ____________
SAVINGS $ ____________
OTHER $ ____________
OTHER $ ____________

20. CHECKING $ ____________
STOCKS/BONDS $ ____________
LIFE INS. $ ____________
REAL ESTATE $ ____________
$ ____________

21. MONTHLY EXPENSES	MONTHLY PAYMENT	BALANCE	COMMENTS/PURPOSE
a) Food	$	$	
b) Gas Heat	$	$	
c) Electric	$	$	
d) Water	$	$	
e) Telephone	$	$	
f) Transportation/Gasoline	$	$	
g) Rent/Mortgage Payment	$	$	
h) Second Mortgage	$	$	
i) Alimony, Child Support	$	$	
j) Auto 1	$	$	
k) Auto 2	$	$	
l) Car Insurance	$	$	
m) Life Insurance	$	$	
n) Health Insurance	$	$	
o) Credit Card 1	$	$	
p) Credit card 2	$	$	
q) Credit Card 3	$	$	
r) Bank Loan 1	$	$	
s) Bank Loan 2	$	$	
t) Finance Co. 1	$	$	
u) Finance Co. 2	$	$	
v) Other	$	$	
w Other	$	$	

TOTAL MONTHLY EXPENSES... $ __________

22. REASON FOR REQUEST TO DISCOUNT OR WAIVE DEDUCTIBLE OR CO-PAY AMOUNTS: ____________________

23. PLEASE LIST ANY OTHER FINANCIAL CONDITIONS WHICH SHOULD BE CONSIDERED IN ESTABLISHING A PAYMENT PLAN: ____________________

I hereby authorize representatives of STREAMWOOD BEHAVIORAL HEALTH CENTER to make whatever inquiries necessary to verify the information furnished on this form, or to release any information regarding this hospitalization on any insurance company or third party to seek settlement of this amount. I hereby state that to the best of my knowledge the information given above is true and complete. I further authorize SBHC to review and/or inquire into my credit history using any means available to obtain a current Credit Bureau History Report.

24. ____________________ SIGNED ____________________
Date

25. ____________________ 26. SPOUSE ____________________
Witness