CANYON RIDGE HOSPITAL

(Administration Use Only)

Patient No:_____
Admit Date:_____
Date completed:_____

Approval:_____
_____

Financial Disclosure Form

THIS FORM IS 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.

PATIENT:

1. Name:_____ SSN: _____
   Last First Middle

2. Address:_____
   Street City
   _____
   State Zip

3. Employment: _____
   Employer Phone Number
   _____
   Street City
   _____
   Years of employment

4. Are you disabled?_____ If yes, disability:_____

RESPONSIBLE PARTY:

5. Name:_____ SSN: _____
   Last First Middle

6. Address:_____
   Street City
   _____
   State Zip

7. Employment: _____
   Employer Phone Number
   _____
   Street City
   _____
   Years of employment

8. Are you disabled?_____ If yes, disability:_____

DEPENDENTS OF RESPONSIBLE PARTY (SPOUSE):

9. Name:_____ SSN: _____
   Last First Middle

10. Address:_____
    Street City

    _____
    State Zip

11. Employment: _____
    Employer Phone Number

    _____
    Street City

    _____
    Years of employment

12. Are you disabled?_____ If yes, disability:_____

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

13. Ages: _____
14. Are any of the above dependents employed?_____ Where? _____
15. Are any of the above dependents disabled? _____ Disability: _____
16. Which of the above dependents do not live with you? _____
17. Why? _____

INSURANCE:

18. Is the above patient covered by any health insurance through an employer or private plan? ☐Y ☐N
    If yes, name the primary insurance: _____
    Benefits coverage: _____
    Name of Secondary insurance: _____
    Benefits coverage: _____

REPONSIBLE 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: _____

PLEASE LIST AVAILABLE ASSETS: (Take Home)

CARS	$_____	CHECKING	$_____
HOMES	$_____	STOCKS/BONDS	$_____
SAVINGS	$_____	LIFE INSURANCE	$_____
OTHER	$_____	REAL ESTATE	$_____

OTHER $_____

19. **Monthly Expenses**	**Monthly Payments**	**Balance**	**Comments / Purpose**
a) Food	$ _____	$_____	_____
b) Gas Heat	$ _____	$_____	_____
c) Electric	$ _____	$_____	_____
d) Water	$ _____	$_____	_____
e) Telephone	$ _____	$_____	_____
f) Transportation, Gasoline	$ _____	$_____	_____
g) Rent / Mortgage Payment	$ _____	$_____	_____
h) 2nd 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	$ _____	$_____	_____
t) Bank Loan 1	$ _____	$_____	_____
u) Bank Loan 2	$ _____	$_____	_____
v) Finance Co. 1	$ _____	$_____	_____
w) Finance Co. 2	$ _____	$_____	_____
x) Other	$ _____	$_____	_____
y) Other	$ _____	$_____	_____
Total Monthly Expenses	$ _____		

Please List Any Other Financial Conditions Which Should Be Considered in Establishing a Payment Plan: _____

_____

_____

_____

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

Date _____ Signed _____

Witness _____ Spouse _____