

Financial Disclosure Worksheet

Return Completed Form To:

Renal Physicians, Inc.  
500 Lincoln Park Blvd., Suite 100  
Kettering, OH 45429-6410

Please complete the following and return to the address above. You also will need to send a copy of your last bank statement and your last 1040 Federal Income Tax Statement or form SSA 1099 from the Social Security Admin. It will then be renewed by the administration to determine if an adjustment can be made on your account due to hardship. If you should have any questions please call (937) 222-7987.

<u>Account #</u>	<u>Date</u>
<u>Patient/Guarantor Name</u>	
<u>Address</u>	
<u>Phone(s) #</u>	<u>Social Security #</u>

Please list: (Exclude yourself) All persons living with you.

<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>
1.		
2.		
3.		
4.		
5.		

<u>Your Employer</u>	<u>Number of years there</u>
<u>Spouse's Name</u>	<u>Spouse's Employer</u>
<u>Spouse's SS#</u>	

Complete the following: (PLEASE PROVIDE PROOF OF AMOUNTS)

	<u>Monthly Payment</u>	<u>Balance Owed</u>	<u>True Value</u>
<u>Rent/Mortgage:</u>			
<u>Auto:</u>			
<u>DPL/Vectren:</u>			
<u>Water/Sewer:</u>			
<u>Phone:</u>			
<u>Food/Grocery (per month):</u>			

Credit Cards: \_\_\_\_\_ What Company? \_\_\_\_\_

\_\_\_\_\_

Loans: \_\_\_\_\_ What Company? \_\_\_\_\_

\_\_\_\_\_

Outstanding Bills:

To Whom \_\_\_\_\_ Monthly Payment \_\_\_\_\_ Balance Owed \_\_\_\_\_

\_\_\_\_\_

Medical Insurance Premium Payment: \_\_\_\_\_ (Monthly, yearly)

Household's approximate income: \_\_\_\_\_ (weekly, bi-weekly, monthly)

Annuities, Stocks, Bonds, CD's-Value at maturity: \_\_\_\_\_

Savings account balance: \_\_\_\_\_

Checking account balance: \_\_\_\_\_

Your Monthly Income

Spouse's Monthly Income

Employer Wages: \_\_\_\_\_

Retirement or Pension: \_\_\_\_\_

SS or Disability: \_\_\_\_\_

Unemployment: \_\_\_\_\_

Workers Compensation: \_\_\_\_\_

Child Support/Alimony: \_\_\_\_\_

Any other income: \_\_\_\_\_

Other income from where? \_\_\_\_\_

I have carefully read and submitted the foregoing information on this worksheet to Renal Physicians, Inc. The information is presented as a true and accurate statement of my financial condition on the date indicated.

I authorize Renal Physicians, Inc., to make whatever credit inquiries it deems necessary in connection with this worksheet. I also authorize and instruct any person or consumer reporting agency to furnish to the office any information that it may have or obtained in response to such credit inquiries.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_