VIBRA HEALTHCARE

PATIENT FINANCIAL ASSESSMENT STATEMENT

RESPONSIBLE PARTY NAME: LAST	FIRST	MIDDLE
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY		HOSPITAL ACCOUNT # (S):
SPOUSE		NUMBER OF DEPENDENTS
STREET ADDRESS		HOME PHONE ( )
CITY, STATE & ZIP		WORK PHONE ( )

OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)	
SOCIAL SECURITY #	ADDRESS	
YEARS AT EMPLOYER	SALARY _____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY OTHER INCOME:_____ SOURCE_____	

SPOUSE

OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)	
SOCIAL SECURITY #	ADDRESS	
PHONE ( )	YEARS AT EMPLOYER	SALARY _____ ☐HOURLY ☐BIWEEKLY ☐MONTHLY
OTHER INCOME	SOURCE	

ASSETS		**LIABILITIES/** MONTHLY TOTALS	
CASH ON HAND	$_____	MORTGAGE/RENT PAYMENT	$_____
CHECKING ACCOUNT*	$_____	INSURANCE PREMIUMS:	
SAVINGS ACCOUNT*	$_____	☐AUTO, ☐MEDICAL, ☐HOME	$_____
CREDIT UNION ACCOUNT*	$_____	OTHER: _____	
REAL ESTATE EQUITY	$_____	UTILITIES: ☐ GAS, ☐ ELECT., ☐ WATER, ☐ PHONE	
MOTOR VEHICLES OWNED	$_____		$_____
MAKE/YEAR	VALUE_____	AUTO PAYMENTS	$_____
MAKE/YEAR	VALUE_____	FOOD	$_____
TRUST ACCOUNTS	$_____	OTHER LIABILITIES:	
OTHER SOURCES (STOCK, BONDS)	$_____	DESCRIPTION PAYMENT BALANCE	

*BANK BRANCH (S) & ACCOUNT NUMBERS:

I HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER LAW.

Signature _____ (Date) _____