Business Office
4620 E. Baseline Road
Mesa, AZ 85206
(480) 308-7710

ARIZONA SPINE & JOINT HOSPITAL
Proudly Owned & Operated by Physicians

To Our Patients Applying For The Financial Assistance Program:

In order for us to consider your application we must receive **ALL** the documents listed below. Be advised all information provided is kept confidential.

Please provide the following:

- ☐ The completed financial assistance application.
- ☐ A copy of your prior year's tax return including schedule C if self-employed.
- ☐ If employed, four consecutive weeks copies of your current paycheck stubs.
- ☐ Copies of your last three bank statements; checking and savings accounts.
- ☐ Copies of any outstanding medical bills including doctor bills, ambulance etc.
- ☐ A copy of the State Assistance program (AHCCCS) decision notice.
  NOTE: *"Failure to provide information or failure to participate in the interview" is not acceptable and cannot be used in this application.*

Completing the application is not a guarantee you will be approved for financial assistance and our collection process will continue.

Please return the additional information as soon as possible or contact our office to discuss your account. You may reach me at {480) 308-7710, Monday through Friday 7:00 a.m. till 3:00 p.m.
Thank you

Sincerely,

Krista Leamy
Collections

ARIZONA SPINE & JOINT HOSPITAL
Proudly Owned & Operated by Physicians

ACCOUNT#: _____

PATIENT NAME:_____

FINANCIAL STATEMENT

LAST NAME (RESPONSIBLE PARTY)	FIRST	MIDDLE	SOC SEC N	BIRTHDATE
MAILING ADDRESS			HOW LONG	PHONE
CITY	STATE			ZIP

PATIENT IF DIFFERENT FROM ABOVE		
RESPONSIBLE PARTY EMPLOYER (NAME & FULL ADDRESS)		
	PHONE	MONTHLY GROSS PAY $
OTHER EMPLOYER (NAME & ADDRESS)		
	PHONE	MONTHLY GROSS PAY $
IF UNEMPLOYED NAME LAST EMPLOYER (NAME & ADDRESS)		
		LAST EMPLOYED DATE

	FAMILY MEMBERS	BIRTHDATE	RELATIONSHIP	EMPLOYED BY	EMPLOYER PHONE(#)
1					
2					
3					
4					
5					

☐ RENT ☐ OWN

OTHER MONTHLY INCOME	$	(SPECIFY SOURCE)

OWED TO OTHERS	To Whom Owed	PRESENT BALANCE	MONTHLY PAYMENT	ASSETS	Bank Name & Account Number	BALANCE OF ACCOUNT
RENT/ MORTGAGE				CHECKING		$
UTILITIES				SAVINGS OR CERTIFICATE		
FOOD				401K PLAN		
AUTO LOAN				STOCK& BONDS		
AUTO INSURANCE				IRA		
CREDIT CAROS				AUTO (YEAR & MAKE)		
				AUTO (YEAR & MAKE)		
				RESIDENCE MARKET VALUE		
Other obligations (Example: Insurance Payments, Child Support, Alimony)				INSURANCE CASH VALUE		
'ADDITIONAL INFORMATION SEE BACK				OTHER ASSETS DESCRIBE		
				TOTAL ASSETS		

PLEASE COMPLETE AND SIGN THE REVERSE SIDE

DATE COMPLETED _____

MEDICAL EXPENSES - PLEASE INCLUDE BILLS OR STATEMENTS OF BALANCE

PATIENT LIABILITY Expenses:
(Enter only those expenses for which the patient or responsible party is totally responsible for paying)

A. PHYSICIAN (S) BILLS:

_____ _____ _____
_____ _____ _____
_____ _____ _____

B. PRESCRIPTION DRUG MEDICATIONS:
(Purchased regularly monthly/weekly etc.) _____ _____

C. EYE CARE: _____ _____

D. DENTAL BILLS: _____ _____

E. HOSPITAUHEALTHCARE FACILITY BILLS:

_____ _____ _____
_____ _____ _____
_____ _____ _____

F. OTHER MEDICAL BILLS/EXPENSES:

_____ _____ _____
_____ _____ _____
_____ _____ _____

G. TOTAL OTHER EXPENSES (Add Lines A through F):

_____ _____ _____
_____ _____ _____
_____ _____ _____

COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I CERTIFY THAT ALL STATEMENTS MADE IN THIS FINANCIAL STATEMENT ARE TRUE AND COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS FINANCIAL STATEMENT.

SIGNATURE: _____ DATE: _____