Financial Evaluation & Request for Financial Assistance

Name of Patient ____

Address ______________________________ City and Zip _____________ Phone ________________

How long have you lived at this address? ____

(If less than one year list previous address)

Birthdate __________________ Birthplace _____________ Number of Dependents ____________

Martial Status ___________ Nearest Relative/Guardian ________________ Relationship ______________

Phone ______________________ Address _______________________________ Zip ____________

Members of Household:

Name:	Relationship	Birthdate	Occupation	Employer's Address	Salary

Financial Resources

Section 1 - INCOME: Patient's Occupation ____

Name & Address of Employer ____

____ Gross Salary $ _________

Years of Employment ____

(If less than one year list previous employment)

Spouse's Occupation ____ Gross Salary $ _________

Years of Employment ____

(If less than one year list previous employment)

Other Types of Income:

Supplemental Security Income $ _____
Old-Age Assistance $ _____
Aid to Disable $ _____
Investments $ _____
Aid to Dependent Children $ _____
Dade County Public Assistance $ _____
Pension $ _____

Vet. Pension $ _____
Social Security $ _____
Social Security- Disabled $ _____
Rental (Income) $ _____
Aid to Blind $ _____
Alimony $ _____
Child Support $ _____
Worker's Compensation $ _____

Unemployment Compensation $ _____
Interest Income $ _____
Stocks/Bonds $ _____
Dividends $ _____
Certificates of Deposit $ _____
Other (Specify $ _____

TOTAL $ ________

S.S. # ______________________ V.A. Serial # ________________ Medicaid ID # __________________

Section 2 - PROPERTY: Homestead-Current Assessed Value $ ______________ Unpaid Balance $ ________

Mortgage Company ____ Monthly Payment $ ___________

Other Property (income-producing property) ____

Current Assessed Value $ _______________ Unpaid Balance $ ___________ Monthly Payment $ _________

Section 3 - SAVINGS:

SAVINGS: Bank __________________________ Account # _________________ Balance $ ___________

CHECKING: Bank _________________________ Account # _________________ Balance $ ___________

CREDIT UNION: Bank _______________________ Account # ________________ Balance $ ___________

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Section 4 - ARE THESE HEALTHCARE SERVICES THE RESULT OF AN ACCIDENT?

Yes ____ No ____ If yes, do you have an attorney? Yes ____ No ____ If yes, attorney's name: ______________

Address ____ Zip __________ Phone _________________

Section 5 - AUTOMOBILE:

Make _______________________________ Model ____ Year _________

Value $ ___________________________________ Unpaid Balance $ _______________________________________

Insurance Company _______________________________________ Policy ___________________________________

Section 6 - OTHER PERSONAL PROPERTY: (Such as other motor vehicles, boats, business equipment).

List showing current value and any unpaid loan amount: ____

____

SECTION 7 - INSURANCE:

Hospitalization _________________________ Policy # ____________________________ Group # _______________

Supplemental Hospitalization _______________________________ Life Insurance Co. ___________________________

Face Value $ _______________________________ Beneficiary _________________ Sickness & Accident __________

SECTION 8 - MONTHLY EXPENDITURES: (Include Installment Payments)

Mortgage/Rent	$ ___________________	Property Taxes	$ ___________________
Telephone	$ ___________________	Lights	$ ___________________
Food	$ ___________________	Other Utilities	$ ___________________
Auto Insurance	$ ___________________	Clothing	$ ___________________
Medical Premiums	$ ___________________	Auto Expenses (Gas, etc)	$ ___________________
Medications	$ ___________________	Miscellaneous Expenses (Specify)	$ ___________________

SECTION 9 - LIST ANY OTHER OUTSTANDING DEBTS: (Credit Cards, Loans, Hospital/Doctors Bills, Etc.)

Company	Balanced Owed	Monthly Payment
	$	$
	$	$
	$	$
	$	$
	$	$

Total Expenses $ _____________________________ Total Income $ _____________________________

NOTICE

The undersigned represent that the applicant has no health insurance or any other payor source (e.g., third party auto insurance, worker's compensation, etc.) for the healthcare services for which this application is being completed. The undersigned also represents that the information provided in this application is true and correct in all material respects.

Each of the undersigned authorizes Joshua Lampert MD PA and Miami Surgery, LLC., and its agents and affiliates to obtain a credit report from a consumer reporting agency for purposes of verifying the information provided by the undersigned and for determining eligibility for financial assistance.

In consideration of Joshua Lampert MD PA and Miami Surgery, LLC. reliance on the representations made herein, the undersigned agree that in the event of any material omission, misstatement or misrepresentation concerning any of the information requested by or provided in this statement, they shall be jointly and severally liable for the charges for all goods, services and treatments furnished the patient by Joshua Lampert MD PA and Miami Surgery, LLC., or its affiliated entities, whether ot not such charges are charged off or otherwise treated as charity, welfare, or bad debt, and further agree that they shall be jointly and severally liable for attorney's fees and costs incurred by Joshua Lampert MD PA and Miami Surgery, LLC., in the enforcement agreement.

The undersigned acknowledge that Section 817.50. Florida Statue, provides that whoever shall willfully and with intest to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of misdemeanor of the second degree.

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SIGNATURE DATE

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WITNESS SIGNATURE DATE