



The completed statement of income and expense form is used to establish a mutually agreeable payment arrangement or other consideration.

When submitting your statement of income and expenses, please include the following (No originals):

- A letter of circumstance indicating your need
- A copy of your most recent pay stub
- A copy of your W-2s
- If receiving public or other assistance, please provide documentation

Please return the requested information within 2 weeks. Southwest Idaho Ear, Nose and Throat will send a written notification of the determination within 3 weeks of receiving your paperwork. If you would like to discuss your financial situation in person please call 208-367-6950.

If this information is not returned, payment in full will be expected.

SOUTHWEST IDAHO EAR NOSE AND THROAT, PA
900 N. Liberty St., Suite 400
Boise, ID 83704

STATEMENT OF INCOME AND EXPENSES

Patient Name: _____ Account: _____ Date: _____

Responsible Party: _____ S.S.#: _____ D.O.B: _____

Address: _____ City and State: _____ Zip: _____

How Long There: _____ Phone: _____ # of Dependants: _____

Name & Address of Employer: _____

Occupation: _____ How Long on Present Job: _____ MO Gross: \$ _____

Employer's Phone: _____ Take-Home Pay: \$ _____

Name & Address of Friend/Next of Kin: _____

Spouse: _____ S.S.#: _____ D.O.B: _____

Spouse's Employer: _____ MO Gross: \$ _____

Employer Phone: _____ Take-Home Pay: \$ _____

Source of Other Income: a.) _____ Amount: \$ _____

b.) _____ Amount: \$ _____

Model & Year of Vehicles: _____ Own or Rent Home: _____

Monthly Living Expense

Medical Expense

Credit Cards

Rent/House: \$ _____	Physician _____ \$ _____	\$ _____ Visa
Groceries: \$ _____	Physician _____ \$ _____	\$ _____ MC
Utilities: \$ _____	Physician _____ \$ _____	\$ _____ Discover
Auto Ins/Maint: \$ _____	Physician _____ \$ _____	\$ _____ AMEX
Health Insurance: \$ _____	Physician _____ \$ _____	\$ _____ Other
Child Care: \$ _____	Physician _____ \$ _____	\$ _____ Total
Auto Loans: \$ _____	Physician _____ \$ _____	<u>Misc. Expense</u>
Cable TV: \$ _____	Physician _____ \$ _____	\$ _____ Total
Cell Phone: \$ _____	Medications _____ \$ _____	
Total: \$ _____	Total \$ _____	

(List additional information on back of form. Please attach documentation.)

Have you or your spouse filed Bankruptcy in the last five (5) years? Yes _____ No _____

Responsible Party Signature: _____ Date: _____