



Patient Financial Services

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MARIA PARHAM MEDICAL CENTER

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| Financial Assessment | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------|---------------|-----------------------------|---------------|------------------------|---------------|
| Account Information | | | | | | | |
| Account # _____ | Balance _____ | Account # _____ | Balance _____ | Account # _____ | Balance _____ | Account # _____ | Balance _____ |
| Account # _____ | Balance _____ | Account # _____ | Balance _____ | Account # _____ | Balance _____ | Account # _____ | Balance _____ |
| Patient/Spouse/Guarantor Information | | | | | | | |
| Patient Last Name _____ | | First Name _____ | | Middle Initial _____ | | | |
| Date of Birth _____ | | SocSec # _____ | | Home Phone# _____ | | | |
| Marital Status(circle one) Married Single Divorced Separated Widowed | | | | | | | |
| Spouse Last Name _____ | | First Name _____ | | Middle Initial _____ | | | |
| Date of Birth _____ | | SocSec # _____ | | | | | |
| # of Dependents in home (including self) _____ | | Ages _____ | | | | | |
| # of other people living in the home: _____ | | Names: _____ | | | | | |
| Mailing Address _____ | | | | | | | |
| Street Address _____ | | | | | | | |
| Housing status Own Buying Renting Other(explain) _____ | | | | Years at this address _____ | | | |
| Previous Address(if <2years at current address) _____ | | | | | | | |
| Employer Information | | | | | | | |
| Patient _____ | | Address _____ | | Phone # _____ | | | |
| Length of time _____ | | Hourly Rate _____ | | Position _____ | | | |
| Spouse _____ | | Address _____ | | Phone # _____ | | | |
| Length of time _____ | | Hourly Rate _____ | | Position _____ | | | |
| Previous employer if less than 2 years | | | | | | | |
| Patient _____ | | Address _____ | | Phone # _____ | | | |
| Spouse _____ | | Address _____ | | Phone # _____ | | | |
| Income | | | | | | | |
| Patient Monthly Gross Income _____ | | Spouse Monthly Gross Income _____ | | | | | |
| Child Support _____ | | Alimony _____ | | Social Security _____ | | Trust Fund _____ | |
| Unemployment _____ | | Retirement _____ | | Food Stamps _____ | | Other(rent, etc) _____ | |
| Expenses: | | | | | | | |
| House Pymt/Rent _____ | | Light Bill _____ | | Phone Home _____ | | Cell _____ | |
| Heating Bill _____ | | Cable _____ | | Water _____ | | | |
| Insurance Home _____ | | Car _____ | | Health _____ | | Life _____ | |
| Car Payment _____ | | Banks _____ | | Furniture _____ | | Credit Cards: _____ | |
| Recreational Vehicles _____ | | Other property _____ | | Phys/Hospital _____ | | Medicine _____ | |
| Groceries _____ | | Daycare _____ | | Other _____ | | | |
| Other information | | | | | | | |
| Do you have Medical Insurance? _____ | | Was that information provided at registration? _____ | | | | | |
| Have you applied for Medicaid? _____ | | When _____ | | Decision _____ | | | |
| Have you applied for Charity Care? _____ | | When _____ | | Decision _____ | | | |
| Have you ever filed Bankruptcy or been a part of bankruptcy proceedings? _____ | | | | | | | |
| Monthly Payments: | | | | | | | |
| Payment Plan Scale | | | | | | | |
| Balance | Terms | Balance | Terms | Balance | Terms | Balance | Terms |
| \$200 or less | 30 days | \$201-\$1,000 | 6 months | \$1001-\$2500 | 12 months | \$2501- \$5000 | 18 months |
| \$5000-\$10000 | 24 months | >\$10,000 | 36 months | | | | |
| Monthly Payments: _____ (minimum payment of \$50.00 per month)starting 30 days from date of service | | | | | | | |
| If unable to make payments according to above scale indicate desired payment _____ | | | | | | | |
| Desired payment will be reviewed and patient will be notified if payment is approved. | | | | | | | |
| If not approved, Maria Parham will make every attempt to make acceptable payment arrangements. | | | | | | | |
| I/We hereby certify all the information furnished on the financial asessment is complete and complete and accurate. I/We authorize you to verify its accuracy. | | | | | | | |
| Patient/Guarantor Signature _____ | | (seal) | | Date: _____ | | | |
| Parent/Spouse Signature: _____ | | (seal) | | Date: _____ | | | |