The Imaging Center

Advanced Medical Imaging Consultants, P.C.
Trusted radiology experts

FINANCIAL WORKSHEET

Patient Name _____ Responsible Party _____

Address _____
Street City State Zip

Phone _____ Employer _____

Spouse _____Spouse Employer _____ Phone #_____

SOURCES OF INCOME

Patient

Employment Income	$	List Other	
Unemployment Benefits	$		
Social Security Benefits	$		
VA Benefits	$		
Child Support/Alimony	$		
Pension Income	$		

Patient Total Monthly Income: $_____ ***

Spouse

Employment Income	$	List Other	
Unemployment Benefits	$		
Social Security Benefits	$		
VA Benefits	$		
Child Support/Alimony	$		
Pension Income	$		

Spouse Total Monthly Income: $_____***

***Income from last years Tax Return (MUST attach copy) $_____ (if you are not able to supply a copy of your Tax Return, please explain why:

ASSETS

Checking Account Balance	$	
Savings Account Balance	$	
Real Estate Residence	Mortgage Balance $	Value $
Other Real Estate	Mortgage Balance $	Value $
Vehicle: Make Yr.	Loan Balance $	Value $
List other assets:		

MONTHLY EXPENSES

EXPENSES	MONTHLY AMOUNT
Rent or Mortgage Expense	**$**
Lot Rent	**$**
Home Owners Dues	**$**
Electricity	**$**
Vehicle expense	**$**
Gas	**$**
Water Sewer Trash	**$**
Telephone	**$**
Cable TV	**$**
Auto Insurance $_____ Home ins. $_____	**$**
Child Support/Alimony	**$**
Child and Elder Care Expense	**$**
Groceries – Weekly	**$**
Auto Maintenance and Gas	**$**
Physician Expenses (List separately on back)	**$**
Hospital Expenses	**$**
Dental Expenses	**$**
Pharmacy Expense	**$**
Health Insurance	**$**
Other Expenses (list on back)	**$**

Credit Cards

Credit Card Company	Amount Due	Monthly Payment
	$	$

Miscellaneous

# of dependants age 17 and under	
# of dependants age 18 and over	
Have you applied for Medicaid?	
If yes were you ever approved?	
Effective Date:	
Have you applied for Disability?	
If yes were you approved?	
Effective Date:	
Was this a work related injury?	
Was this an auto related injury?	

The information on the worksheet is warranted by the undersigned to be complete and accurate to the best of their knowledge. The undersigned does hereby allow AMIC or The Imaging Center to verify all information contained on this worksheet.

_____ _____

Signature of Applicant Date

Comments_____