

Date:

Patient Name:

Patient Address:

Account Number:

Balance Due:

Services were performed at: _____

Advanced Medical Imaging/Radiology Associates/Superior Medical Imaging
7601 Pioneers Blvd
Lincoln, NE 68506

Patient Name: _____ Guarantor: _____

Social Security #: _____ SS# of Guarantor: _____

Relationship to Guarantor: _____ Phone #: _____

Address: _____

Are you currently employed: _____

Employer's name and phone #: _____

Spouse employed?: _____ Where?: _____

Name, age and relationship of dependents living in your household: _____

Your monthly income: _____ Spouses monthly income: _____

Other sources of income: _____

Car: _____ Year: _____ Make: _____ Value: _____

Cash on Hand: _____ Checking acct: _____ Savings acct: _____

Liabilities:

Rent: _____ Landlord: _____

Mortgage payment: _____ Total Mortgage Owed: _____

Utilities(gas, electricity, water): _____

List significant monthly expenses (loans, medical, personal, credit cards, etc.)

Please use the back of this sheet if necessary.

	Monthly payment	Total due
1.) _____		
2.) _____		
3.) _____		
4.) _____		

Please attach a copy of the following: x **Prior year's income tax form x **Prior year's W-2 form** x **Payroll stubs****

I, _____, certify that the facts set forth in this Financial Disclosure Form are true and correct to the best of my knowledge. I give Advanced Medical Imaging/Radiology Associates/Superior Medical Imaging authority to verify the above information.

Guarantor's signature: _____ Date: _____