STANFORD
UNIVERSITY
MEDICAL CENTER
Stanford Hospital and Clinics
Lucile Packard Children's Hospital

PROFESSIONAL SERVICES OPERATIONS
Physician Billing
Phone: (650) 498-5850
Fax: (650) 856-3939

Credit References/Authorization for Credit Check

Patient Name: _____ MRN: _____

BANK:	BANK PHONE:
BANK ADDRESS:	Acct. Numbers Savings: Checking: Loan:
❑ Own home ❑ Rent	Monthly rent/mortgage: $
Mortgage held by:	Address:
LOANS	
Bank or Major Credit Card:	Monthly payment: $ Balance: $
Bank or Major Credit Card:	Monthly payment: $ Balance: $
Bank or Major Credit Card	Monthly payment: $ Balance: $
Creditor:	Monthly payment: $ Balance: $
Creditor:	Monthly payment: $ Balance: $
INCOME	
Total Monthly Income: $	Total Annual Income: $

Please FAX this form and a copy of your last pay stub or Federal Income Tax Return or W2 form to **(650) 498-6488** one week prior to the patient's scheduled surgery date.

I certify that all of the above information is valid and complete. I hereby authorize Stanford Health Services to Request a credit check report and/or verify any of the above information as deemed necessary.

_____ _____
Signature Date

_____
Print Name

Rev. 10/07