

APPLICATION FOR CREDIT



Procedure Amount: \$	Down Payment Amount Collected: \$
Tentative Procedure Date:	Application Submission Date:

Patient ID #:
Provider ID #:

APPLICANT INFORMATION					
Last Name, First Name Middle Initial Suffix			Social Security Number	Date of Birth	
Physical Address		City		State	Zip
Years there	Type of Housing	Housing Payment \$	US Citizen	Drivers License #	
Home Phone		Alt Phone		Email Address	
By providing an e-mail address, I consent to receive email confirmation of my Application, communications about my Account and periodic offers and updates from Healthcare Finance Direct, LLC.					
Previous Address if above is less than 3 years			City, State Zip		Years There

EMPLOYMENT INFORMATION					
Employer Name		Position	Years There	Job Status	
Work Phone	Gross Monthly Pay-NO LESS THAN \$2,000 COMBINED \$		Other Household Income (Monthly) \$		Source
Previous Employer if less than 3 years		Position	Years There	Work Phone	Checking
You need not include spouse's income, alimony, child support or maintenance payments paid to you if you are not relying on them to establish creditworthiness. Spouse must also sign application EXCEPT in WA, ID, NV, WI, CA, AZ, NM, TX, & LA, if spouse's income is to be considered as "other income" by applicant.					

ADDITIONAL REQUIRED INFORMATION			
Nearest Relative or Personal Reference not living with you (Other than to Co-Applicant)			Phone Number

CO-APPLICANT'S INFORMATION		CO APPLICANT MUST BE IMMEDIATE FAMILY			
Last Name, First Name Middle Initial Suffix			Social Security Number	Date of Birth	
Physical Address		City, State Zip			
Years there	Type of Housing	Housing Payment \$	US Citizen	Driver's License #	
Home Phone		Alt Phone		Email Address	
By providing an e-mail address, I consent to receive email confirmation of my Application, communications about my Account and periodic offers and updates from Healthcare Finance Direct, LLC.					
Previous Address if above is less than 3 years			City, State Zip		Years There
Employer Name		Position	Years There	Job Status	
Work Phone	Gross Monthly Pay \$		Other Household Income (Monthly) \$		Source

APPLICANT SIGNATURE					
By submitting this application I have verified that all information submitted on this application is true and correct to the best of my knowledge. I authorize Healthcare Finance Direct, LLC ("HFD") and/or its assigns to verify the enclosed information, including, but not limited to obtaining my credit report, contacting my employer to verify employment and income, and/or contacting my Provider to verify the type of procedure(s), procedure date, deposit amount, procedure amount, product, sales price and remit payment upon approval. I understand and agree that HFD or its assigns can furnish information concerning my account to consumer reporting agencies and others who may properly receive that information. Furthermore, I am signing that a Provider's staff member may submit this application on my behalf and that I have read this disclosure and agree to the conditions set forth herein. I also agree that this application and any information I submitted with it may be forwarded to other creditors. HFD and/or these other creditors, will provide me any other required disclosures. By signing below, I further agree that such other creditors may obtain a credit report and use it in making a credit decision.					
Applicant Signature		Date	Co-applicant Signature		Date
Representative Entering Application		Provider Phone	Provider Fax	Email Address:	

Fax Application to: 661-466-5333 Phone: 877-874-3877