APPLICATION FOR CREDIT (For Use in Non-Community Property States)

Office Use Only		
Procedure Amount: $	Down Payment Amount Collected: $	Provider Name:
Tentative Procedure Date:	Application Submission Date:	Provider ID#:

This is an application for credit offered by the Provider identified above. Healthcare Finance Direct, LLC ("HFD") does not offer credit. HFD is contracted by the Provider to provide services to the Provider. Applicant, if married, may apply for separate credit.

IMPORTANT: PLEASE READ THESE DIRECTIONS BEFORE COMPLETING THIS APPLICATION.

Check Appropriate Box

- ☐ If you are applying for individual credit in your own name and are relying on your own income or assets and not the income or assets of another person as the basis for repayment of the credit requested, complete all Sections other than the Co-Applicant/Other Person Section.
- ☐ If you are applying for joint credit with another person, complete all Sections, providing information in the Co Applicant/Other Person Section about the joint applicant.

  We intend to apply for joint credit. _____ Applicant _____ Co-Applicant
- ☐ If you are applying for individual credit, but are relying on income from alimony, child support or separate maintenance or on the income or assets of another person as the basis for repayment of the credit requested, complete all Sections to the extent possible, providing information in the Co Applicant/Other Person Section about the person on whose alimony, support or maintenance payments or income or assets you are relying.

APPLICANT INFORMATION

Last Name	First Name	Middle	Suffix	Social Security Number	Date of Birth

Mailing Address	City	State	Zip

Years There	Circle One	Housing Payment	US Citizen	Drivers License #
	RENT / OWN / LIVE WITH OTHER	$	Y N	

Home Phone	Cell Phone	Email Address
( )	( )	

Previous Address (if above is less than 3 years)	City	State	Zip	Years There

Employer Name	Position	Years There	Circle if Applicable
			RETIRED / SELF-EMPLOYED / HOMEMAKER / STUDENT

Work Phone	Gross Monthly Pay	Other Income (Monthly)*	Other Income Source
( )	$	$	

*Alimony, child support or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation. Alimony, child support, separate maintenance received under: ☐ court order ☐ written agreement ☐ oral understanding

Nearest Relative or Personal Reference not living with you (Other than Co-Applicant/Other Person)	Phone Number
	( )

CO-APPLICANT/OTHER PERSON INFORMATION

Last Name	First Name	Middle	Suffix	Social Security Number	Date of Birth

Mailing Address	City	State	Zip

Years There	Circle One	Housing Payment	US Citizen	Drivers License #
	RENT / OWN / LIVE WITH OTHER	$	Y N	

Home Phone	Cell Phone	Email Address
( )	( )	

Previous Address (if above is less than 3 years)	City	State	Zip	Years There

Employer Name	Position	Years There	Circle if Applicable
			RETIRED / SELF-EMPLOYED / HOMEMAKER / STUDENT

Work Phone	Gross Monthly Pay	Other Income (Monthly)*	Other Income Source
( )	$	$	

*Alimony, child support or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation. Alimony, child support, separate maintenance received under: ☐ court order ☐ written agreement ☐ oral understanding

APPLICANT(S) SIGNATURE(S)

By submitting this application, I certify that all information submitted on this application is true and correct to the best of my knowledge. I authorize Healthcare Finance Direct, LLC ("HFD"), as service provider on behalf of the Provider identified above 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, and sales price. I understand and agree that my Provider, HFD or its assigns can furnish information concerning my account to consumer reporting agencies and others who may properly receive that information. Furthermore, I agree that a Provider's staff member may submit this application on my behalf to HFD. I also agree that this application and any information I submitted with it may be forwarded to other creditors. By signing below, I further agree that such other creditors may obtain a credit report and rely on it in making a credit decision.

Applicant Signature	Date	Co-Applicant Signature	Date

Name of Provider Staff Member	Provider Phone	Provider Fax	Email Address
	( )	( )	

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