LOAN APPLICATION

Please use black ink and print clearly

MEDICAL FINANCING SOLUTIONS

PATIENT INFORMATION

First Name | Middle Initial | Last Name | Social Security Number

E-mail Address | Mobile/Alternate Telephone Number ( ) | Have you ever declared bankruptcy? ❑Yes ❑No | If yes when? (month/year) | ❑Dismissed ❑Discharged ❑Unresolved

Current Address | City | State | Zip | Date of Birth / /

Home Phone ( ) | Time at Current Address Years Months | ❑Own Home ❑Rent ❑Parents/Relatives ❑Other | Monthly Rent/Mortgage $

Current Employer | Position | **Gross** Income $ ❑Week ❑Month ❑Year | Time at Current Employer Years Months

Current Business Phone ( ) | Current Employer Street Address | City | State | Zip

*Other Income (Including Spouse) $ ❑Week ❑Month ❑Year | Source of Other Income

**You do not have to include alimony, child support, or separate maintenance income unless you want us to consider it as basis for repayment.*

COMPLETE ONLY IF YOU HAVE MOVED OR CHANGED JOBS IN THE PAST 2 YEARS

Previous Address (If less than 2 years at current address) | City | State | Zip | Time at Previous Address Years Months

Previous Employer (If less than 2 years at current employer) | Position | Time at Previous Employer Years Months

Previous Business Phone ( ) | Previous Employer Street Address | City | State | Zip

Would you like to use your home as collateral? ❑Yes ❑No

Estimated Property Value: $

Estimated Mortgage Balance $

CO-APPLICANT INFORMATION (OPTIONAL)

First Name | Middle Initial | Last Name | Social Security Number

E-mail Address | Mobile/Alternate Telephone Number ( ) | Have you ever declared bankruptcy? ❑Yes ❑No | If yes when? (month/year) | ❑Dismissed ❑Discharged ❑Unresolved

Current Address | City | State | Zip | Date of Birth / /

Home Phone ( ) | Time at Current Address Years Months | ❑Own Home ❑Rent ❑Parents/Relatives ❑Other | Monthly Rent/Mortgage $

Current Employer | Position | **Gross** Income $ ❑Week ❑Month ❑Year | Time at Current Employer Years Months

Current Business Phone ( ) | Current Employer Street Address | City | State | Zip

*Other Income (Including Spouse) $ ❑Week ❑Month ❑Year | Source of Other Income | Relationship to Patient

**You do not have to include alimony, child support, or separate maintenance income unless you want us to consider it as basis for repayment.*

COMPLETE ONLY IF YOU HAVE MOVED OR CHANGED JOBS IN THE PAST 2 YEARS

Previous Address (If less than 2 years at current address) | City | State | Zip | Time at Previous Address Years Months

Previous Employer (If less than 2 years at current employer) | Position | Time at Previous Employer Years Months

Previous Business Phone ( ) | Previous Employer Street Address | City | State | Zip

TERMS & CONDITIONS OF THIS LOAN APPLICATION

Notice: By completing the Pre-qualification Loan application form and faxing it to 800-730-1014 you are giving EFS (eFinancing Solutions) and / or their lending companies, including, but not limited to, Banks, Finance Partners, Credit Card Issuers and other types of companies, written authorization to access your credit profile for Pre-qualification purposes. I understand ESF will be acting as a loan-processing agent on my behalf and therefore does not set the rate and terms of my loan, approve or deny, discriminate against anyone for any reason or guarantee my loan approval. I understand that there may be additional fees and discounts associated with my loan approval and that I may be charged a loan processing fee if I elect to accept the terms of my loan. Furthermore, while calculated monthly, I understand that the total amount of the fees will be added to my base loan amount requested and become a part of my principal balance. I understand that EFS is obligated to explain these fees to me before I sign additional loan documents. I agree to "hold harmless" EFS from any and all legal actions that might be taken as a result of a disputed mater with my Service Provider or Vendor.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF CO-APPLICANT _____ DATE _____

Amount Requested: $_____

Date Submitted: _____

Medical Provider: Vein Centers for Excellence of KC
11409 Ash Ste B
Leawood KS 66211
O-913-451-8346 F-913-451-8347

PHONE IN REQUESTS TO 1-800-728-9585 OR FAX TO 1-800-730-1014

Or to apply online, go to www.mymedicalfinancing.com