

THIS IS A MEDICAL BILL Have questions about your bill?
Call us: (469) 1111111

PATIENT's Invoice
Invoice Number: MR111116



BILL SUMMARY

Payment Due

Your Insurance has been billed. Your balance is below.
Please pay:

\$367.83

Statement Date
4/11/2019



Pay Online
(Recommended)

Visit: <https://sample.website>



Pay By Phone

Call customer service:
(469) 111-1111



Pay By Mail

Detach payment coupon and submit with a check or credit card information

*



Need to set up a payment plan? Call us at **(469)111-1111**

CHARGES SUMMARY

SERVICE DATE	DESCRIPTION	CHARGE	INSURANCE PAYMENTS	DISCOUNTS	PATIENT PAYMENTS	BALANCE
6/17/2018	Seen at Code 3 ER at DFW Airport	\$10,979.54	\$10,611.71	\$0.00	\$0.00	\$367.83



2390 Innovation Drive
Suite 100
DFW Airport TX-Texas, 752619428

Has your insurance or patient information changed?
Please check this box and indicate any changes on the reverse side.

If paying by credit, debit or flexible spending card, complete this section.

Guarantor: GUARANTOR Invoice Number: MR111116

VISA
 MasterCard
 DISCOVER
 AMEX

Card Number _____ Name on Card _____

Signature _____ CVV _____ Exp. Date _____ Zip Code _____

\$367.83	STATEMENT DATE 4/11/2019	DUE DATE ON RECEIPT	AMOUNT ENCLOSED
----------	-----------------------------	------------------------	-----------------





Include your account number on checks payable to :
Code 3 ER at DFW Airport

SAMPLE PATIENT
SAMPLE ADDRESS
PROVIDENCE VILLAGE, TX 76227-5496

Code 3
PO BOX 840787
Dallas, TX 75284-0787

EH I TEST CLINIC
 100 EAGLE ROCK AVENUE
 SUITE 306
 EAST HANOVER, NY 07936

IF PAYING BY CREDIT CARD, FILL OUT BELOW.

 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>	 <input type="checkbox"/>
CARD NUMBER		SIGNATURE CODE	
SIGNATURE		EXP. DATE	
STATEMENT DATE 11/14/2016	PAY THIS AMOUNT \$780.00	ACCT. # 1001760	
SHOW AMOUNT PAID HERE			\$

ADDRESSEE:

FIRSTNAME LASTNAME
 123 TESTING AVENUE
 2ND FLOOR
 EAST HANOVER, NJ 07936

REMIT TO:

BILLINGPROVIDER
 100 EAGLE ROCK AVENUE
 MILTON, VT 05468

Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Date	Patient Name	Phys	Description	Charges	Patient Resp.	Insurance Receipts	Patient Receipts	Adjust	Patient Balance
07/24/2014	FirstName LastName	TestPhysic ian	OFFICE VISIT, EST PAT COMPREHENSIVE(99214)	\$370.00		\$0.00	\$0.00	\$0.00	\$370.00
07/24/2014	FirstName LastName	TestPhysic ian	PERCUT ALLERGY SKIN TESTS(95004)	\$50.00		\$0.00	\$0.00	\$0.00	\$50.00
05/12/2014	FirstName LastName	TestPhysic ian	ADULT DAY CARE PER HALF DAY(S5101)	\$190.00	\$60.00	\$110.00	\$40.00	\$40.00	\$60.00
03/13/2014	FirstName LastName	TestPhysic ian	BRAIN ANEURYSM REPR, COMPLX(61697)	\$14,930.00	\$300.00	\$13,000.00	\$0.00	\$1,630.00	\$300.00

0-30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	151 + Days	Total Balance	*Ins. Pending	Now Due
\$0.00	\$0.00	\$0.00	\$0.00	\$780.00	\$780.00	\$2,125.00	\$0.00	\$780.00

Patient Account Information

Copayment	Deductible	Coinsurance	Others	Account Number	Statement Date
\$10.00	\$350.00	\$0.00	\$0.00	1001760	11/14/2016

MAKE CHECKS PAYABLE TO

Message

BILLINGPROVIDER 100 EAGLE ROCK AVENUE MILTON, VT 05468	Test Footer Patient Office Administrative Charges => \$ 420.00
BILLING QUESTIONS (973)339-3078	

PHONE :
EMAIL :
FAX :



PATIENT STATEMENT

STATEMENT REFERENCE ID : E11111112

THIS CHARGE IS FOR THE LABORATORY TESTING THAT WAS ORDERED BY YOUR PHYSICIAN **TEST PHYSICIAN**

STATEMENT DETAILS

Patient Name : SAMPLE PATIENT
Account Number : 1111
Date of Service : 12/12/2018
Statement Date : 4/4/2019
Referring Physician : TEST PHYSICIAN

Pay Online Via
<https://synergenpay.com>



STATEMENT SUMMARY

Total Amount Due: \$210.00

Description of Charges	Total Charge	Insurance Payment	Patient Payment	Total Adjustment	Patient Balance
GRAND TOTAL	\$5,418.75	\$0.00	\$0.00	\$5,208.75	\$210.00
G0483 - DRUG TEST(S), DEFINITIVE, UTILIZING DRUG	\$4,197.64	\$0.00	\$0.00	\$4,057.74	\$139.90
80307 - DRUG TEST(S), PRESUMPTIVE, ANY NUMBER OF	\$1,221.11	\$0.00	\$0.00	\$1,151.01	\$70.10

ALL OTHER DESCRIPTION OF CHARGES WILL BE CONTINUED ON SUBSEQUENT PAGES.

MESSAGE FOR YOU

CONTACT US

PHONE :
EMAIL :
FAX :

RETAIN THIS TOP PORTION OF STATEMENT FOR YOUR TAX RECORDS.

DETACH AND RETURN BOTTOM PORTION WITH REMITTANCE. PLEASE INDICATE ANY ADDRESS CHANGES ON BACK.



Genesis Reference Laboratories LLC
7924 Forest City Rd Suite 210
Orlando FL 32810-2907

Account Number : 1111
Date of Service : 12/12/2018
Statement Reference ID : E111111112
Total Amount Due : \$210.00

IF PAYING BY CHECK, FILL BELOW

Check Number (Provide Last Five Digits)

MAKE CHECK PAYABLE AND REMIT TO:
Genesis Reference Laboratories LLC
7924 Forest City Rd Suite 210
Orlando FL 32810-2907

SAMPLE PATIENT
SAMPLE ADDRESS
ELKTON, MD 21921-5812

THIS IS YOUR BILL

Have questions about your bill?

Call us: 888-111-1111

SAMPLE PATIENT's Account

Account: 71

RODOLFO R. BATARSE, MD, MEDICAL

BILL SUMMARY

New Charges \$471.10

All Adjustments \$214.62

Payment Due

Your Insurance has been billed.
Your balance is below.

Please pay:

\$30.00

Payment is due by:

05/11/2019



Pay By Mail

Send in your check along with the payment coupon below.



Pay By Phone

Call customer service:
888-111-1111



Pay Online

May Not Be Available

Visit: [SAMPLE.WEBSITE](#)
Payment Code:



* Need to set up a payment plan? Call us at 888-111-1111

We would like to thank you for being our patient, and for choosing us to serve you. If you have any concerns about your bill or think that we may not have your correct insurance information, please do not hesitate to call us at 888-111-1111. Thanks once again!

RODOLFO R. BATARSE, MD, MEDICAL
71511 HIGHWAY 111
SUITE H
RANCHO MIRAGE, CA 922704465

SAMPLE PATIENT
SAMPLE ADDRESS
PALM DESERT, CA 92211-6248

Payment Due - Please pay \$30.00

Your payment is due by 05/11/2019

Account 11111

Amount Enclosed

Include your account number on checks payable to :
RODOLFO R. BATARSE, MD, MEDICAL

RODOLFO R. BATARSE, MD, MEDICAL
71511 HIGHWAY 111
SUITE H
RANCHO MIRAGE CA, 922704465

RETURN MAIL ONLY:



ARIZONA CENTER FOR Hand to Shoulder Surgery

Securely pay your bill online at
www.achssurgeons.com

PATIENT
RESPONSIBILITY

\$50.00

PAYMENT
DUE BY

05/11/2019

OR

See reverse side for payment by credit card or check.

ADDRESSEE:

MAKE CHECKS PAYABLE AND REMIT TO:

SAMPLE PATIENT
SAMPLE ADDRESS
PEORIA, AZ 85345-2531

ARIZONA CENTER FOR HAND SURGERY
PO BOX 7587
PHOENIX, AZ 85011-7587

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

Acct #: 1111111

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

04/11/2019

DATE OF SERVICE	DESCRIPTION OF SERVICE	CHARGES	INSURANCE PAYMENTS/ADJ.	PATIENT RESPONSIBILITY
11/02/2018	Claim:171237, Provider: Steven D. Bastian, MD			
11/02/2018	Facility: St Joseph Westgate Medical Center OP			
11/02/2018	15574 Form skin pedicle flap - Units 1.00	\$3,467.00	\$2,535.54	\$50.00

MESSAGE: This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services.

*Save a stamp! Pay online at www.achssurgeons.com or Scan this QR Code with your SmartPhone to pay.

Statement ID: 593
Password: YxF48548b

ARIZONA CENTER FOR
Hand to Shoulder Surgery
PO Box 7587
Phoenix, AZ 85011-7587
602-258-4788

PATIENT
RESPONSIBILITY:

\$50.00

PAYMENT DUE BY:

05/11/2019

ACCOUNT NUMBER:

1111111

FOR BILLING QUESTIONS REFER TO BACKSIDE OF STATEMENT