THIS IS A MEDICAL BILL Have

questions about your bill?

Call us: (469) 111111111

BILL SUMMARY

Payment Due

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

\$367.83

Statement Date

4/11/2019

PATIENT's Invoice

Invoice Number: MR111116





Pay By Phone

Pay By Mail

Visit: https://sample.website

Call customer service: (469) 111-1111

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 PA	PATIENT AYMENTS	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.

> SAMPLE PATIENT SAMPLE ADDRESS PROVIDENCE VILLAGE, TX 76227-5496

If paying by credit, debit or flexible spending card, complete this section.								
Guarantor: GUARA	ANTOR	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

Code 3 PO BOX 840787 Dallas, TX 75284-0787 EHI TEST CLINIC 100 EAGLE ROCK AVENUE SUITE 306 EAST HANOVER, NY 07936

ADDRESSEE:

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

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

100000000000000000000000000000000000000		CARD, FILL OUT	
CARD NUMBER	MasterCard	DISCOVER	SIGNATURE CODE
SIGNATURE			EXP. DATE
STATEMENT DATE 11/14/2016	23.07.02.0	S AMOUNT 780.00	ACCT.# 1001760
		SHOW AMO	

REMIT TO:

BILLINGPROVIDER 100 EAGLE ROCK AVENUE MILTON, VT 05468

07	CAT		B. Al	-	45
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PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Date	Patient Name	Phys	Description	Charges	Patient Resp.	Insurance Receipts	Patient Receipts	Adjust	Patient Balance
07/24/201	4 FirstName LastName	TestPhysic ian	OFFICE VISIT, EST PAT COMPREHENSIVE(99214)	\$370.00		\$0.00	\$0.00	\$0.00	\$370.00
07/24/201	4 FirstName LastName	TestPhysic ian	PERCUT ALLERGY SKIN TESTS(95004)	\$50.00		\$0.00	\$0.00	\$0.00	\$50.00
05/12/201	4 FirstName LastName	TestPhysic ian	ADULT DAY CARE PER HALF DAY(S5101)	\$190.00	\$60.00	\$110.00	\$40.00	\$40.00	\$60.00
03/13/201	4 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 Day	s 151 + Days	Total Balance	*Ins. Po	ending	Now Due
\$0.00	\$0.0	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 Deductible					tement Date					
\$10.00)		\$350.00	\$0.00		\$0.00	.00 1001760 11/14/20			1/14/2016
	M	AKE CH	IECKS PAYABLE	ТО			Message	е		
100 EAGL	BILLINGPROVIDER 100 EAGLE ROCK AVENUE MILTON, VT 05468					t Footer ient Office Adminis	strative Charges	=> \$ 420	.00	
WILLION, V	WILLION, VI 00400						BILLING QUES	STIONS		
							(973)339-3	078		

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

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 Amo	ount Due: \$2	210.00	
Description of Charges	Total Charge	Insurance Payment	Patient Payment	Total Adjustment	Patient Balance
GRAND TOTAL	\$5,418.75	\$.00	\$.00	\$5,208.75	\$210.00
G0483 - DRUG TEST(S), DEFINITIVE, UTILIZING DRUG	\$4,197.64	\$.00	\$.00	\$4,057.74	\$139.90
80307 - DRUG TEST(S), PRESUMPTIVE, ANY NUMBER OF	\$1,221.11	\$.00	\$.00	\$1,151.01	\$70.10

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

MESSAGE FOR YOU CONTACT US

PHONE :

⋕ FAX

RETAIN THIS TOP PORTION OF STATEMENT FOR YOUR TAX RECORDS.

1111

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

Account Number

ENESIS

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

*IF PAYMENT HAS ALREADY BEEN MADE PLEASE DISREGARD THIS STATEMENT.

THIS IS YOUR BILL

Have questions about your bill?

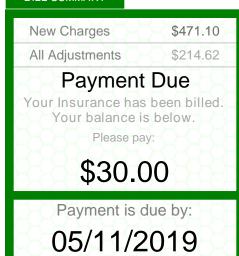
Call us: 888-111-1111

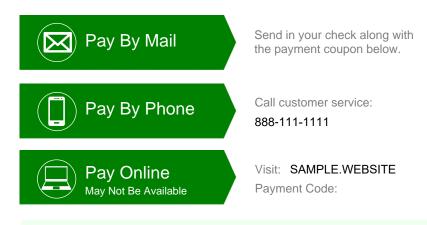
SAMPLE PATIENT's Account

Account: 71

RODOLFO R. BATARSE, MD, MEDICAL

BILL SUMMARY







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	$\langle \cdot \rangle \prec \langle$

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



Securely pay your bill online at www.achssurgeons.com

PAYMENT DUE BY PATIENT RESPONSIBILITY \$50.00 05/11/2019

OR

See reverse side for payment by credit card or check.

MAKE CHECKS PAYABLE AND REMIT TO:

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

ADDRESSEE:

SAMPLE PATIENT **SAMPLE ADDRESS** PEORIA, AZ 85345-2531

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 RESPONSIBILIT
1/02/2018 1/02/2018 1/02/2018	Claim:171237, Provider: Steven D. Bastian, MD Facility: St Joseph Westgate Medical Center OP 15574 Form skin pedicle flap - Units 1.00	\$3,467.00	\$2,535.54	\$50.00
ESSAGE:	This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services.	PATIENT RESPONSIBI	LITY:	\$50.00
	*Save a stamp! Pay online at www.achssurgeons.com or Scan this QR Code with your SmartPhone to pay.	PAYMENT DI	JE BY:	05/11/2019
	Statement ID: 593 Password: YxF48548b	ACCOUNT N	LIMDED:	1111111

602-258-4788

FOR BILLING QUESTIONS REFER TO BACKSIDE OF STATEMENT

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