RETURN MAIL ONLY:

MailMyStatements — Technology Driven Billing and Payment Solutions

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:

SAMPLE PATIENT
SAMPLE ADDRESS
PEORIA, AZ 85345-2531

MAKE CHECKS PAYABLE AND REMIT TO:

MailMyStatements
SAMPLE ADDRESS

☐ 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:			
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

PATIENT RESPONSIBILITY:	$50.00
PAYMENT DUE BY:	05/11/2019
ACCOUNT NUMBER:	1111111

FOR BILLING QUESTIONS REFER TO BACKSIDE OF STATEMENT

55078293

SAMPLE ADDRESS
SAMPLE PHONE NUMBER

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

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	$.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), PRESUMP	$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 :
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.

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)

MailMyStatements
Technology Driven Billing and Payment Solutions

MAKE CHECK PAYABLE AND REMIT TO:

SAMPLE ADDRESS

SAMPLE PATIENT
SAMPLE ADDRESS
ELKTON, MD 21921-5812

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

THIS IS A MEDICAL BILL Have questions about your bill?
Call us: (469) 11111111

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

Visit: https://sample.website

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

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE ( )

MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME TELEPHONE ( )

EMPLOYER'S ADDRESS CITY STATE ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS TELEPHONE ( )

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME TELEPHONE ( )

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

55073953

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

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

Send in your check along with the payment coupon below.

Call customer service:
888-111-1111

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

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

SAMPLE PATIENT
SAMPLE ADDRESS
PALM DESERT, CA 92211-6248

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

55079516

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

Explanation of your bill

Cost of services		Insurance Paid		Previously Paid		Adjusted Amount		Owed by you
$471.10	—	$150.69	—	$15.00	—	$48.93	=	**$30.00**
		Amount insurance paid after deductibles and co-pay		Co-pay or previous payments made by you		Reduction in your balance due to billing agreements between your doctor and your insurance		

CHARGES SUMMARY

Date	Description	Charge	Insurance Payment	Patient Payment	Adjustment	Patient Balance
2019-04-10	76499	$50.00	$25.00	$15.00	$10.00	**$0.00**
2019-04-10	76942	$127.74	$87.19	$0.00	$25.55	**$15.00**
2019-04-10	73560	$66.88	$38.50	$0.00	$13.38	**$15.00**
2019-03-01	99214	$226.48	$0.00	$0.00	$0.00	**PEND**

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY | STATE | ZIP

TELEPHONE ( ) | MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME | TELEPHONE ( )

EMPLOYER'S ADDRESS | CITY | STATE | ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME | EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS | TELEPHONE ( )

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME | TELEPHONE ( )

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

THIS IS A FINAL BILL
Have questions about your bill?
Call us: (800) 456-7890

Howard's Account
Account: **2881**
Bill for dates: **06/01/16 - 06/13/16**

BILL SUMMARY

New Charges	**$12,054.25**
All Adjustments	**-$5,245.35**

Payment Due

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

$25.09*

Payment is due by:

6/21/2018

Pay Online *(Recommended)*

Visit: www.mailmystatements.com/pay
Statement Number: **30996612**
Password: **PcwzdY**

Pay By Mail

Send in your check along with the payment coupon below.

Pay By Phone

Call customer service:
(800) 456-7890

* Need to set up a payment plan? Call us at (800) 456-7890

You can view this bill in greater detail online:
www.mailmystatements.com/pay
Scan this symbol or enter the statement number online

Charge Breakdown

#	Service	Billed On	Patient	Amount Billed	Insurance Paid	Amount You Owe
1	Follow-up Exam	8/25/2017	Howard	$0.00	$0.00	**$5.97**
2	Hospital Stay	9/21/2017	Howard	$0.00	$0.00	**$7.88**
3	Urgent Care Exam	9/28/2017	Howard	$0.00	$0.00	**$11.24**

1234 Bib Drive Ave.
Glendale CA 91203

Payment Due - *Please pay*	**$25.09**
Your payment is due by	**6/21/2018**
Account	**2881**
Amount Enclosed	

Include your account number on checks payable to :
Mail My Statements

HOWARD P ROARK
501 N CENTRAL AVE # 903
GLENDALE, CA 91203-1901

Mail My Statements
165 Caprice Ct
Castle Rock, CO 80109

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

30996612

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE ( )

MARITAL STATUS
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

EMPLOYER'S NAME TELEPHONE ( )

EMPLOYER'S ADDRESS CITY STATE ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS TELEPHONE ( )

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME TELEPHONE ( )

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

*Denotes that an insurance claim has been filed.

We remain open and ready to serve you throughout COVID-19.

Balance Due

$30.00

Upon Receipt

Statement Date: 03/29/2023

Patient Name:
ALDOFO BIOY CESARES

Account Number:
03X46764563

Questions? Please contact us at ***(800) 456-7890***

Pay Online *(Recommended)* To pay and enroll in electronic billing scan QR code or go to https://pay.balancecollect.com and enter your code: **ABC123**

Payment Plan Call us at **(800) 456-7890**

PAST DUE STATEMENT

Service Date	Description of Service	Charge	Payment/ Adjustments	Patient Responsibility
03/24/2023	D0999 - Patient Office Visit Copay	$0.00	$0.00	$0.00
03/24/2023	D1110 - Prophy Adult	*70.00	$20.00	$50.00
03/24/2023	D1999 - Infection Control and PPE	*0.00	$0.00	$0.00
03/29/2023	Estimated Due From Insurance	*0.00	$20.00	$0.00
				$30.00

Total Balance	Current Balance	30-60 Days	60-90 Days	90+ Days
$30.00	**$50.00**	$0.00	$0.00	$0.00

165 CAPRICE CT.
CASTLE ROCK, CO 80109

Balance Due:	$30.00
Due Date:	04/28/2023
Account Number:	03X46764563
Enter Amount Enclosed:	

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

Please make checks payable to: **ABC Healthcare**

ABC HEALTHCARE
165 CAPRICE CT.
CASTLE ROCK, CO 80109

ALDOFO BIOY CESARES
5301 S SUPERSTITION MOUNTAIN DR STE 104
ROOM 412-A /C/O-LIFE CARE CENTER
PALOS VERDES PENINSULA, CA 90274-1401

150709700

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or your responsibility as a patient.

How much do I really owe?

You are responsible for the amount listed in the box PATIENT RESPONSIBILITY. As every insurance plan is different, if you disagree with how your insurance paid on your account, please contact them prior to contacting our office.

What if I cannot pay in full?

Please call our patient account representatives at the number listed on the front of this statement.

Co-Pay:

A dollar amount contracted between you and your insurance carrier, due at time of service.

Co-Insurance:

A percentage of the insurance benefits that you are responsible for.

Deductible:

A yearly dollar amount that you are responsible for based on the type of coverage you have selected with your insurance company.

Adjustment:

A contractual agreement that has been made between our Doctors and your insurance company.

For your convenience, we offer the following payment options:

- **Cash**
- **Personal Checks**
- **Credit Cards**

Payment is due in full by the PAYMENT DUE DATE indicated on the front of this statement.

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY | STATE | ZIP

TELEPHONE ( ) | MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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EMPLOYER'S ADDRESS | CITY | STATE | ZIP

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PRIMARY INSURANCE COMPANY'S ADDRESS | TELEPHONE ( )

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME | TELEPHONE ( )

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

150709700

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

IF PAYING BY CREDIT CARD, FILL OUT BELOW.

VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS ☐

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
11/14/2016	$780.00	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	TestPhysician	OFFICE VISIT, EST PAT COMPREHENSIVE(99214)	$370.00		$0.00	$0.00	$0.00	$370.00
07/24/2014	FirstName LastName	TestPhysician	PERCUT ALLERGY SKIN TESTS(95004)	$50.00		$0.00	$0.00	$0.00	$50.00
05/12/2014	FirstName LastName	TestPhysician	ADULT DAY CARE PER HALF DAY(S5101)	$190.00	$60.00	$110.00	$40.00	$40.00	$60.00
03/13/2014	FirstName LastName	TestPhysician	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

54867844