

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

PATIENT
RESPONSIBILITY:

\$50.00

PAYMENT DUE BY:

05/11/2019

ACCOUNT NUMBER:

1111111

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

FOR BILLING QUESTIONS REFER TO BACKSIDE OF STATEMENT





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 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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> 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 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

THIS IS YOUR BILL

Have questions about your bill? Call us: 888-111-1111

PATIENT'S Account

Account: 71

RODOLFO R. BATARSE, MD, MEDICAL

PAGE 2 OF 2

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	<input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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

1 Follow-up Exam

BILLED ON: 8/25/2017

AMOUNT BILLED: \$0.00

AMOUNT YOU OWE: **\$5.97**

PATIENT: Howard

INSURANCE PAID: \$0.00

2 Hospital Stay

BILLED ON: 9/21/2017

AMOUNT BILLED: \$0.00

AMOUNT YOU OWE: **\$7.88**

PATIENT: Howard

INSURANCE PAID: \$0.00

3 Urgent Care Exam

BILLED ON: 9/28/2017

AMOUNT BILLED: \$0.00

AMOUNT YOU OWE: **\$11.24**

PATIENT: Howard

INSURANCE PAID: \$0.00



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

Mail My Statements

165 Caprice Ct

Castle Rock, CO 80109

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

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

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	<input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> 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.

Patient Name:
ALDOFO BIOY CESARES

Account Number:
03X46764563


Balance Due

\$30.00

Upon Receipt

Statement Date: 03/29/2023

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

 **Pay Online** To pay and enroll in electronic billing scan QR code or go to
(Recommended) <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 \$30.00	Current Balance \$50.00	30-60 Days \$0.00	60-90 Days \$0.00	90+ Days \$0.00
--	--	----------------------	----------------------	--------------------



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.

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

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

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

ABC HEALTHCARE
165 CAPRICE CT.
CASTLE ROCK, CO 80109

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	<input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> 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	

EHI 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