



**Thank you for choosing My Medical Office
for all your family's health care needs.**

Statement Date: 09/01/2015
Responsible Party: John Q. Patient
Account Number: 123456789
Due Date: **Upon Receipt**

REQUEST FOR PAYMENT

Account Summary

Patient Name: John Q. Patient
Date of Service: 08/01/2015

Total Charges	\$ 6,850.00
Insurance Payments / Adjustments	\$ 0.00
Patient Payments	- \$ 50.00
Total Account Balance	\$ 6,800.00

AMOUNT YOU OWE \$ 6,800.00

PLEASE PAY IMMEDIATELY

Important Message

Payment is due upon receipt. Prompt payment is appreciated. Thank you!

Please see payment options below or call our Billing Department to make payment arrangements.

To pay statement online please visit www.paystatementonline.com

Insurance Information

If your insurance has changed, please call our Billing Department immediately at 800-123-4567 or complete and mail the Change of Health Insurance Information Form on the back of this statement.

Payment and Other Information



Securely pay online at www.paystatementonline.com using your smartphone or computer. Additionally, view visit and payment history, as well as print receipts and statements.



If you need to speak to our Billing Department, please call 800-123-4567. M-F: 8AM - 6 PM or email us at youofficeemail@sample.com.



123 Any Street
Anytown, US 12345

Pay By Mail Account #: 123456789

Amount Due	Due Date	Amount Paid
\$6,800.00	Upon Receipt	\$

Credit Card Number	Exp. Date	Circle Card
Credit Card Holder's Signature	CVV Code	

JOHN Q PATIENT
123 MAIN STREET
ANYTOWN, US 12345-6789

COLLABORATEMD
P.O. BOX 1234
ANYTOWN, US 12345



Account Activity: John Q Patient

Account Number: 123456789

Date of Service: 08/01/2015

<u>Date</u>	<u>Description</u>	<u>Activity</u>
08/01/2015	Outpatient Surgery	\$ 5,750.00
08/01/2015	Radiology	500.00
08/01/2015	Pharmacy	600.00
08/01/2015	Patient payment	- 50.00
Total Account Balance		\$ 6,800.00

YOUR BALANCE IS NOW PAST DUE

Important Information

If you believe this statement is in error, or if you can provide us with additional insurance coverage and it is not too late to file a claim, please call our Billing Department immediately.

Billing Department
 P: 800-123-4567
 F: 800-111-2222

If you have questions concerning other statements, please use the information below to contact the service providers directly:

Medical Hospital
 123-456-7890

Medical Office
 123-456-7890

Medical Radiology
 123-456-7890

Medical Pathology Group
 123-456-7890

CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

JOHN Q PATIENT
123456789

If you have new health insurance or a new address, please enter the information below

NEW ADDRESS		CITY	STATE	ZIP CODE	NEW PHONE#
POLICY HOLDER'S NAME/RELATIONSHIP TO PATIENT			POLICY ID #		GROUP#
EFFECTIVE DATE	BIRTH DATE OF INSURED	HMO/PPO/OTHER		INSURANCE PHONE #	
IF GROUP INSURANCE, NAME OF GROUP (EMPLOYER, UNION/ASSOCIATION)					INSURANCE PHONE#
INSURANCE COMPANY NAME			INSURANCE ADDRESS		
EMPLOYER			EMPLOYER ADDRESS		