CMD
SAMPLE LOGO

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 (All Accounts)

Total Charges	**$ 7,400.00**
Insurance Payments / Adjustments	- $ 5,000.00
Patient Payments	- $ 150.00
AMOUNT YOU OWE	**$ 2,250.00**

Your prompt payment is appreciated!

Important Message

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

Please see payment information below or contact our Billing Department at 800-123-4567.

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.

To pay statement online please visit
www.paystatementonline.com Payment Portal

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.

Payment methods include mail, online, and over the phone.

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

CMD
SAMPLE LOGO

123 Any Street
Anytown, US 12345

Pay By Mail

Amount Due	Due Date	Amount Paid
$2,250.00	Upon Receipt	$

Credit Card Number	Exp. Date	Circle Card
Credit Card Holder's Signature	CVV Code	VISA MasterCard AMEX DISCOVER

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

COLLABORATEMD
P.O. BOX 1234
ANYTOWN, US 12345

01X12345678901234500058890

SAMPLE LOGO

Patient Name: John Q. Patient

Service Date	Account Number	Description of Service	Charges	Insurance Payments/ Adjustments	Patient Payments	Pending Insurance	Amount You Owe
08/01/2015	123456789	EMERGENCY ROOM	$ 1,650.00	- $ 1,500.00	- $ 50.00	$ 0.00	$ 100.00
08/01/2015	987654321	OUTPATIENT	$ 2,550.00	- $ 1,500.00	- $ 50.00	$ 0.00	$ 1,000.00

Thank you for allowing us to service your health care needs. Payment is due upon receipt. Prompt payment is appreciated. Please call our Billing Department for questions at 800-123-4567 or to discuss payment options.

Patient Name: John Q. Patient

Service Date	Account Number	Description of Service	Charges	Insurance Payments/ Adjustments	Patient Payments	Pending Insurance	Amount You Owe
08/01/2015	123456781	EMERGENCY ROOM	$ 3,200.00	- $ 2,000.00	- $ 50.00	$ 0.00	$ 1,150.00

Thank you for allowing us to service your health care needs. Payment is due upon receipt. Prompt payment is appreciated. Please call our Billing Department for questions at 800-123-4567 or to discuss payment options.

Due Date	Amount You Owe
Upon Receipt	**$ 2,250.00**

CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

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	