Thank you for choosing us for all your health care needs.

Statement Date:	11/27/2023
Responsible Party:	JOHNNY TEST
Account Number:	53851815
Due Date:	Upon Receipt

REQUEST FOR PAYMENT

Account Summary (All Accounts)

Total Charges:	$370.00
Insurance Payments/Adjustments:	-$200.00
Patient Payments:	-$50.00
AMOUNT YOU OWE	**$120.00**

Important Message

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

Please see payment information below or contact our Billing Department for assistance.

Your prompt payment is appreciated!

Insurance Information

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

Pay your balance online! Scan the QR code or go to paystatementonline.com

Payment Portal

Payment and Other Information

Please pay by mail, online, or over the phone

Securely pay online at 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 M-F: 8AM - 6PM or email us at your earliest convenience.

CMD FAMILY PRACTICE - EAS
111 N MAGNOLIA AVE
STE 1100
ORLANDO, FL 32801-0011

Address Service Requested

JOHNNY TEST
1010 FAKE WAY
APOPKA, FL 32703

Pay By Mail

Account# 53851815
Invoice# 1150745141

Amount Due	Due Date	Amount Paid
$120.00	Upon Receipt	$

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

CMD FAMILY PRACTICE - EAST
111 N MAGNOLIA AVE
STE 1100
ORLANDO, FL 32801-0011

Patient: TEST, JOHNNY (#53851815) Next Appointment: 11/09/2023

Provider: BAKER, JAMES

Service Date	Description of Service	Total Charges	Insurance Payments / Adjustments	Patient Payments	Other Adjustments	Amount You Owe
06/02/2023	HRT FAILURE ASSESSED	$370.00	-$200.00	-$50.00	$0.00	$120.00

Please call us if you have any questions regarding these charges.

Due Date	AMOUNT YOU OWE
Upon Receipt	**$120.00**

CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

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

NEW ADDRESS	CITY	STATE	ZIP CODE	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 COMPANY NAME	INSURANCE ADDRESS
EMPLOYER	EMPLOYER ADDRESS