CMD SAMPLE LOGO

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:	11/27/2023

PAYMENT PLAN BALANCE DUE

Payment Plan Summary

Payment Plan Amount:	$120.00
Payment Plan Balance:	$120.00
Next Installment Amount:	$20.00
AMOUNT DUE NOW	$20.00

Important Message

Payment is due upon receipt. Prompt payment is appreciated. Thank you!
Please see payment information below or contact our Billing Department.

Your prompt payment is appreciated!

Have your needs changed?

If your needs for a payment plan have changed, please contact our Financial Counselors immediately. Modifications to current payment plans are made on a case by case basis.

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 www.paystatementonline.com using your smart phone 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 SAMPLE LOGO

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# 1150750064

Amount Due	Due Date	Amount Paid
$20.00	11/27/2023	$

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)

Plan Id: 10087546

Due Date	Description	Amount	Payments / Adjustments	Balance	Due Now
11/27/2023	Installment 1 of 6	$20.00	$0.00	$20.00	$20.00
12/27/2023	Installment 2 of 6	$20.00	$0.00	$20.00	$0.00
01/27/2024	Installment 3 of 6	$20.00	$0.00	$20.00	$0.00
02/27/2024	Installment 4 of 6	$20.00	$0.00	$20.00	$0.00
03/27/2024	Installment 5 of 6	$20.00	$0.00	$20.00	$0.00
04/27/2024	Installment 6 of 6	$20.00	$0.00	$20.00	$0.00

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

Due Date	AMOUNT DUE NOW
11/27/2023	**$20.00**

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