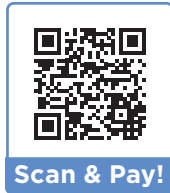




GRAHAM MEDICAL ASSOCIATES  
123 Main Street  
Anytown, USA 12345-6789

**Patient Account**

Patient John Doe  
Account Number 555924  
Statement Date 05/15/2022



**Pay Online**  
[www.grahammedassociates.com](http://www.grahammedassociates.com)

Online Bill Pay Code	<b>BPC5D3</b>
Patient Responsibility	<b>\$197.88</b>
Payment Due Date	<b>06/05/2022</b>



**MESSAGE:** If you are unable to make your payment in full, please register online or call our office to set up a payment plan.

**Billing Questions:** (123) 456-7890 x123  
See reverse side for important billing information. ▶ ▶ ▶

# PAST DUE NOTICE

PATIENT NAME	TOTAL PATIENT RESPONSIBILITY	PAYMENT DUE DATE
<b>John Doe</b>	<b>\$197.88</b>	<b>06/05/2022</b>

## Past Due Notice

This is a friendly reminder that you have an outstanding patient balance. We realize that life is busy and this could be a simple oversight.

**Please remit your payment within 15 days.** If you cannot pay in full or need to arrange a special payment plan please contact our office at (123) 456-7890.

Thank you for your cooperation in this matter.

Sincerely,

Billing Department  
Graham Medical Associates

*Please call our billing department if you have questions or need to set up a payment plan.*

▲ Keep top portion for your records ▲

▼ Mail bottom portion with mailed payments ▼

### Billing Summary

Patient John Doe  
Account Number 555924  
Statement Date 05/15/2022

<b>PATIENT RESPONSIBILITY</b> <b>\$197.88</b>	<b>ONLINE BILL PAY CODE</b> <b>BPC5D3</b>	<b>PAYMENT DUE DATE</b> <b>06/05/2022</b>
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To pay by mail, make checks payable to



123 Main Street  
Anytown, USA 12345-6789

JOHN DOE  
456 PARKER ST  
ANYTOWN, USA 12345-0621

**GRAHAM MEDICAL ASSOCIATES**  
**123 MAIN ST**  
**ANYTOWN USA 12345-6789**





### Pay Online

[www.grahammedassociates.com](http://www.grahammedassociates.com)

Guest Pay or Register  
Sign up for eStatements,  
or set up a payment plan!



### Text to Pay

The easy way to pay your bill.  
Sign up for Text to Pay at  
[www.grahammedassociates.com](http://www.grahammedassociates.com)



### Pay by Phone

& Billing Questions  
(123) 456-7890 x123  
Mon-Thurs: 8:00am - 4:30pm  
Fri: 8:00am - 12:00pm



### Pay by Mail

Checks payable to:  
Graham Medical Associates  
123 Main Street  
Anytown, USA 12345-6789

## 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 or go online to set up a payment plan.

### 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:

Annual 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.

## PLEASE UPDATE ANY INFORMATION THAT HAS CHANGED SINCE YOUR LAST STATEMENT

IF PAYING BY CREDIT CARD, FILL OUT BELOW			
SEE FRONT FOR ACCEPTED CREDIT CARDS	CARD TYPE		
	CARD NUMBER		
AUTHORIZATION CODE: _____ <small>(usually last 3 or 4 digits on back of card in signature line)</small>			
SIGNATURE	EXP. DATE		
<input type="checkbox"/> PAYING BY CHECK <table border="1" style="float: right;"> <tr> <td>SHOW AMOUNT PAID HERE</td> <td>\$</td> </tr> </table>		SHOW AMOUNT PAID HERE	\$
SHOW AMOUNT PAID HERE	\$		

PRIMARY INSURANCE COMPANY NAME
INSURANCE COMPANY'S ADDRESS
CITY STATE ZIP
POLICY HOLDER NAME HOLDER'S DOB RELATIONSHIP TO INSURED
INSURED'S ID NUMBER GROUP PLAN NUMBER
SECONDARY INSURANCE COMPANY NAME
INSURANCE COMPANY'S ADDRESS
CITY STATE ZIP
INSURED'S ID NUMBER GROUP PLAN NUMBER

ADDRESS CORRECTION	
COMPLETE THIS SECTION IF YOUR ADDRESS ON REVERSE SIDE IS INCORRECT	
NAME	
ADDRESS	
CITY	
STATE, ZIP	

