



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

Patient Account

Patient John Doe
Account Number 555924
Statement Date 11/15/2021

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



Pay Online
www.grahammedassociates.com

Online Bill Pay Code	BPC5D3
Patient Responsibility	\$197.88
Payment Due Date	12/05/2021



Billing Questions: (123) 456-7890 x123

See reverse side for important billing information. ▶ ▶ ▶

PAST DUE NOTICE

PATIENT NAME	TOTAL PATIENT RESPONSIBILITY	PAYMENT DUE DATE
John Doe	\$197.88	12/05/2021

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 ▲



123 Main Street
Anytown, USA 12345-6789

▼ Mail bottom portion with mailed payments ▼

Billing Summary		
Patient	John Doe	
Account Number	555924	
Statement Date	11/15/2021	
PATIENT RESPONSIBILITY	ONLINE BILL PAY CODE	PAYMENT DUE DATE
\$197.88	BPC5D3	12/05/2021

To pay by mail, make checks payable to

GRAHAM MEDICAL ASSOCIATES
123 MAIN ST
ANYTOWN USA 12345-6789

JOHN DOE
456 PARKER ST
ANYTOWN, USA 12345-0621





Pay Online

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



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	SHOW AMOUNT PAID HERE \$

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

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	

