GRAHAM
MEDICAL ASSOCIATES

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

Scan & pay or visit us online at
www.grahammedassociates.com

Online Bill Pay Code	**BPC5D3**
Patient Responsibility	**$197.88**
Payment Due Date	**12/05/2025**

Patient Account

Patient	John Doe
Account Number	555925
Statement Date	11/20/2025

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
John Doe	**$197.88**	**12/05/2025**

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

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

JOHN DOE
456 PARKER ST
ANYTOWN, USA 12345-0621

Mail bottom portion with mailed payments

Billing Summary

Patient	John Doe
Account Number	555925
Statement Date	11/20/2025

PATIENT RESPONSIBILITY	ONLINE BILL PAY CODE	PAYMENT DUE DATE
$197.88	**BPC5D3**	**12/05/2025**

To pay by mail, make checks payable to

GRAHAM MEDICAL ASSOCIATES
123 MAIN ST
ANYTOWN USA 12345-6789

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: ____ ____ ____ ____
(usually last 3 or 4 digits on back of card in signature line)

SIGNATURE

EXP. DATE

☐ 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