

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.



Payment Due Date

12/05/2025

MERICAN EXPRESS



Billing Questions: (123) 456-7890 x123

See reverse side for important billing information. **•** •

	PAST DUE NOT	ICE		
DATE	DESCRIPTION	CHARGES	PAYMENTS & ADJUSTMENTS	PATIENT RESPONSIBILITY
09/21/25 09/21/25 09/21/25 10/02/25 10/02/25 10/02/25	John Doe (555925) / Casey M Arnold MD Office visit Blood count Basic metabolic panel Insurance adjustment Insurance payment Patient payment	165.00 49.00 59.00 - 25.22	- 82.16 - 30.00	
10/02/25	BALANCE John Doe (555925) / Casey M Arnold MD	100.00		135.62
10/02/25 11/08/25 11/08/25	Office Visit Insurance adjustment Insurance payment BALANCE	108.00	- 34.94 - 10.80	62.26

Keep top portion for your records

G GRAHAM MEDICAL ASSOCIATES

123 Main Street Anytown, USA 12345-6789

JOHN DOE 456 PARKER ST ANYTOWN, USA 12345-0621

igwedge Mail bottom portion with mailed payments igwedge

Billing Summary			
Patient	John Doe		
Account Number 555925		,	
Statement Date 11/20/2025		025	
PATIENT RESPONSIBILITY	ONLINE BILL PAY CODE	PAYMENT DUE DATE	
\$197.88	BPC5D3	12/05/2025	

To pay by mail, make checks payable to



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:

A yearly 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		BELOW	PRIMARY INSURANCE COMPANY NAME		
SEE FRONT CARD TYPE FOR ACCEPTED CREDIT CARDS			INSURANCE COMPANY'S ADDRESS		
CARD NUMBER AUTHORIZATION CODE: (usually last 3 or 4 digits on back of card in signature line)			CITY STATE ZIP		
SIGNATURE		EXP. DATE	POLICY HOLDER NAME HOLDER'S DOB RELATIONSHIP TO INSURED		
PAYING BY CHECK	SHOW AMOUNT PAID HERE	\$	INSURED'S ID NUMBER GROUP PLAN NUMBER		
ADDRESS CORRECTION COMPLETE THIS SECTION IF YOUR ADDRESS ON REVERSE SIDE IS INCORRECT			SECONDARY INSURANCE COMPANY NAME		
NAME			CITY STATE ZIP		
ADDRESS			INSURED'S ID NUMBER GROUP PLAN NUMBER		
CITY					
STATE, ZIP					