



BPC5D3

\$197.88

12/05/2025



See reverse side for important billing information. ▶ ▶ ▶





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

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	