

PINEHURST SURGICAL

excellence in practice

P.O. BOX 2000
PINEHURST, NC 28374

31342

PAGE: 1 of 1

(910) 295-6831

PLEASE RETURN PAYMENT COUPON WITH PAYMENT.

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

MASTERCARD
 DISCOVER
 VISA
 AMERICAN EXPRESS

CARD NUMBER _____ SIGNATURE CODE _____

SIGNATURE _____ EXP. DATE _____

STATEMENT DATE	STATEMENT BALANCE	ACCT. #
11/14/2007	14.78	9999999
DUE DATE	SHOW AMOUNT PAID HERE	\$
12/05/2007		

651021D



0001

JOHN PATIENT
 1234 MAIN ST
 ANYTOWN, USA 99999-9999

PATIENT NAME

PINEHURST SURGICAL
 5 FIRST VILLAGE DRIVE
 PO BOX 2000
 PINEHURST, NC 28374-2000

ACCOUNT NUMBER

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

31342*T870JDKG3000002

PATIENT: JOHN PATIENT

ACCOUNT ACTIVITY

DATE	DOCTOR NAME	DESCRIPTION	CHARGES	ADJUSTMENTS	PAYMENTS	BALANCE
08/31/07	SMITH	X-RAY SERVICES	90.00			
09/19/07		MEDICARE PAYMENT			20.38-	
09/19/07		MEDICARE FORWARD CLAIM TO COMP IN				
09/19/07		MEDICARE ADJUSTMENT		64.53-		5.09
08/31/07	JONES	OFFICE VISIT	88.00			
09/19/07		MEDICARE PAYMENT			38.74-	
09/19/07		MEDICARE FORWARD CLAIM TO COMP IN				
09/19/07		MEDICARE ADJUSTMENT		39.57-		9.69
09/19/07		*AMOUNT DUE*				

AMOUNT DUE BY PATIENT

ACCOUNT NUMBER	ACCOUNT TOTAL	0 - 29 DAYS	30 DAYS	60 DAYS	90 DAYS	120+ DAYS	CHARGE THIS STATEMENT	PAYMENTS THIS STATEMENT
9999999	14.78	.00	14.78	.00	.00	.00	178.00	59.12-

MESSAGE:

PLEASE SUBMIT PAYMENT IMMEDIATELY

Pay your bill online at www.pinehurstsurgical.com

PLEASE PAY THIS AMOUNT

14.78

PINEHURST SURGICAL

excellence in practice P.O. BOX 2000 PINEHURST, NC 28374

31342*T870JDKG3000002

0% Interest available, please ask a Financial Counselor



IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . .

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE ()

MARITAL STATUS Separated
 Single Divorced
 Married Widowed

EMPLOYER'S NAME TELEPHONE ()

EMPLOYER'S ADDRESS CITY STATE ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS TELEPHONE ()

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS TELEPHONE ()

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

PLEASE READ INFORMATION ON BACK OF STATEMENT

Pinehurst Surgical Billing and Payment Policies

- Payment for deductibles, co-payments, co-insurance, and non-covered services is expected at the time of service.
- If your health insurance plan requires a preauthorization or referral, it is your responsibility to obtain it before your appointment.
- Services received as a result of an accident are to be paid in a timely manner. We do not delay payment for lawsuits or liability insurance carriers.
- The **PLEASE PAY THIS AMOUNT** balance is due by statement due date.
- Payments may be made by cash, check, money order, MasterCard, VISA, American Express, Discover, or Care Credit .
- If you are not able to pay your balance in full by statement due date, please call 910-235-9761 to make payment arrangements. Please use the chart below to establish a payment plan.

Current Balance	Pay Increments	Months to Pay Balance
\$0.00 to \$300.00	\$ 50.00	3 to 6
\$301.00 to \$1200.00	\$100.00	12
\$1201.00 to \$2700.00	\$150.00	18
\$2701.00 to \$4800.00	\$200.00	24
\$4801.00 to \$9000.00	\$250.00	36
\$9000.00 and up	48 equal payments	48

- It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.

