An example Billing Statement

MAKE CHECKS PAYABLE TO:

PRICE VISION GROUP
9002 N. MERIDIAN ST #100
INDIANAPOLIS, IN 46260-5349

CALL 1(317) 846-7557 WITH
QUESTIONS OR CONCERNS
PATIENT NAME: JOHN DOE

PLEASE BILL MY (CIRCLE ONE): VISA MC V-Code _____

Acct. No. _____ Exp. Date _____

Signature _____

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
05/14/2009	**149.61**	CL12345678

SHOW AMOUNT PAID HERE $

ADDRESSEE:

01-A 20090514 PSH1 S 00001

JOHN DOE
7708 GREEN MEADOWS DR
LEWIS CENTER OH 43035-4999

Amount and Account Number

REMIT TO:

PRICE VISION GROUP
9002 N. MERIDIAN ST #100
INDIANAPOLIS IN 46260-5349

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

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Service Date	Doctor	Description	Charge	Insurance Payment	Patient Payment	Adjust	Balance
02/12/09	FPRICE	NP LEVEL 4	150.00	108.43	.00	14.46	27.11
02/26/09	FPRICE	CATARACT REMOVAL + IOL	2585.00	490.02	.00	1972.48	122.50

Please remit payment within fifteen (15) days.

Should you have any questions or concerns regarding this statement, please call ou office at (317)846-7557 8:00 am - 4:00 pm.

THIS AMOUNT REFLECTS ADDITIONAL CHARGES CURRENTLY AWAITING A RESPONSE FROM YOUR INSURANCE CARRIER. YOU MAY ULTIMATELY BE RESPONSIBLE FOR ALL OF THESE CHARGES.	INSURANCE PENDING	PLEASE PAY THIS AMOUNT
	150.00	**149.61**

NOTICE: SEE REVERSE SIDE FOR ADDRESS CHANGE AND INSURANCE INFORMATION!