

# Outpatient Services Billing Statement

Statement Date: \_\_\_\_\_

Patient Name

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Statement Number

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Date of Birth

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Patient ID

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Address

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Phone

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Services Provided

Date of Service	Procedure/Service	CPT/Code	Provider	Charge	Insurance Payment	Patient Payment	Balance

Total Charges

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Total Insurance Payments

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Total Patient Payments

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**Amount Due**

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Comments / Notes

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Please remit payment to:

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