

Outpatient Services Billing Statement

Statement Date: _____

Patient Name

Statement Number

Date of Birth

Patient ID

Address

Phone

Services Provided

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

Total Charges

Total Insurance Payments

Total Patient Payments

Amount Due

Comments / Notes

Please remit payment to:
