LOGO

Billing Statement

Patient Name:
_____
Statement Date:
_____
Statement #:
_____
Provider:
_____
Provider Address:
_____
Phone:
_____
Account #:
_____
Insurance:
_____

Date of Service	Description	Service Code	Charges	Insurance Payment	Patient Payment	Adjustments	Balance
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Total Charges: _____

Total Insurance Payments: _____

Total Adjustments: _____

Total Patient Payments: _____

Amount Due: _____

Notes/Instructions:

_____
_____

Thank you for your prompt attention to this statement.