Medical Payment Statement

Patient & Provider Information

Patient Name:

Patient ID:

Date of Birth:

Provider:

Provider NPI:

Service Location:

Statement Details

Statement Number: **Date Issued:**

Service Date(s): **Account Number:**

Service & Payment Summary

Date	Service Description	Procedure Code	Charge	Adjustment	Insurance Payment	Patient Responsibility	Amount Paid	Balance Due
	Totals							

Total Balance Due

Amount Due: **Due Date:**

Notes / Instructions

- This is a summary of services and payments. Please verify with your insurance for details.
- If you have questions regarding this statement, contact our billing office.
- Please pay your balance by the due date to avoid late fees.