



STATEMENT

SHOW AMOUNT PAID HERE \$ _____

NEW BALANCE

\$33.28

Payment is due within 10 days of receipt.

OFFICE PHONE NUMBER
903 614-3000

CLOSING DATE
08/30/2003

ACCOUNT NUMBER
100012345

PAGE

CREDIT CARD PAYMENT check here
Complete the form below and return in the enclosed envelope.

Amount \$ _____

Card Expires ___/___ Type of Card _____

Card Number _____

Card Holder's Name _____

Signature _____

Federal law requires that we advise you that the purpose of this communication is to collect a debt, and that any information obtained will be used for that purpose.

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT.

Date	Inv #	Dr Name	SvcCode	Service Description	Patient Name	Charges /Debits	Payments /Credits	Patient Balance
07/08/03				Previous Balance				\$24.96
03/01/03	25	DOE MD, J J	99212	OFFICE-ESTABLISHED,	JOHN	\$48.50		\$8.32
05/20/03	25	DOE MD, J J	00030	BC/BS OTHER PAYMENT			(\$33.32)	
05/20/03	25	DOE MD, J J	99982	BC/BS OTHER DISCOUNT			(\$6.86)	
Closing Date 08/08/2003					JOHN		100012345	
Account Ageing	Current	31-60 Days	61-90 Days	> 90 Days	Total	NEW BALANCE		
Patient	\$0.00	\$8.32	\$0.00	\$24.96	\$33.28	PAY THIS AMOUNT		
* Insurance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$33.28		

SEND INQUIRIES/PAYMENTS TO:



P.O. BOX 1409
TEXARKANA, TEXAS 75504
(903) 614-3000

PLEASE INCLUDE YOUR ACCOUNT NUMBER WITH ALL CORRESPONDENCE