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| Claim # | Service Dates | Procedure | Units | Unit Rate | Total charge | Ins  Paid | Fee scale | Client  Charge | Client Paid | Due |
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A logo for a health department

AI-generated content may be incorrect.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_#\_\_\_)

Payment Type: ( Cash ☐ / Check ☐ / CC ☐ )

Card Type: ( Visa ☐ / MC ☐ / American Exp ☐ / Discover ☐ )

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_/\_\_\_/\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_\_\_

Amount Enclosed: \_\_\_\_\_\_\_\_\_\_\_

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

**PAY THIS AMOUNT: \_\_\_\_**

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Health Education Services

930 North 10th St

SPEARFISH, SD 57783

P: (605) 717-8920

Source: Fictitious data, for illustration purposes only