

**IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR
LAST STATEMENT, PLEASE INDICATE...**

PATIENT INFORMATION

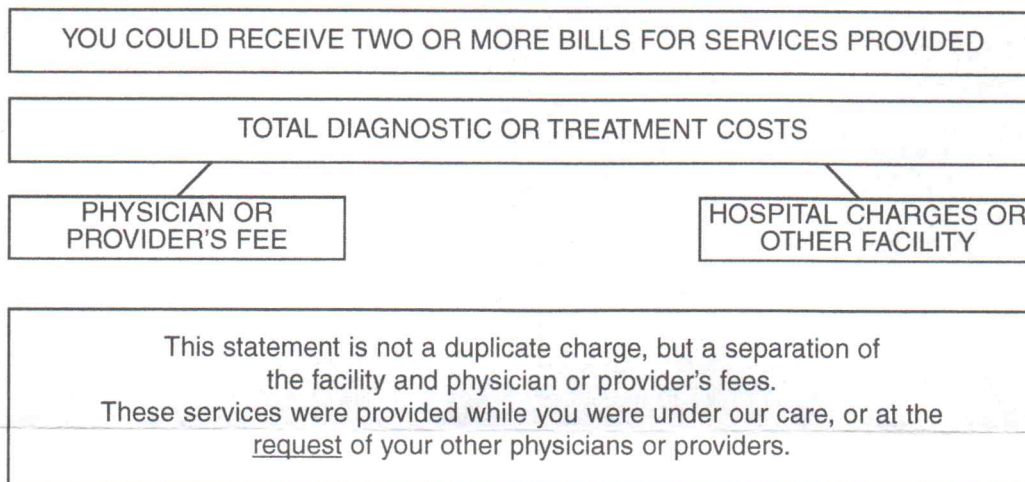
Your Name (Last, First, Middle Initial)	Date of Birth
Address	
City	State Zip
Telephone	
()	
Social Security #	
Employer's Name	Telephone
()	
Employer's Address	
City	State Zip
Please Indicate if Applicable:	
<input type="checkbox"/> AUTO ACCIDENT	Date of Injury
<input type="checkbox"/> WORKER'S COMPENSATION	

INSURANCE INFORMATION

Your PRIMARY Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	
Your SECONDARY Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	

"DETACH HERE AND RETURN ABOVE STUB"

FOR HOSPITAL OR OTHER FACILITY PATIENTS



Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

**IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE
PHONE NUMBER ON THE REVERSE SIDE.**

Foothills Sports Med & Rehab Scottsdal
15410 S Mountain Pkwy Ste 112
Phoenix AZ 85044

RETURN SERVICE REQUESTED

Patient Name: JONATHAN GRIFFITH
Billing Phone: (480) 706-1161
Office Hours: Monday - Friday 8AM-5PM

Stmt ID#: 1097555180



150594 - 860



0037 001575

JONATHAN GRIFFITH (JONATHAN GRIFFITH)
8384 E SOLANO DR
SCOTTSDALE AZ 85250-6228

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW			
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> AMER. EXP.
CARD NUMBER	EXP. DATE	AMOUNT	
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
1/14/2020	\$337.00	F843784907

CHARGES AND CREDITS MADE AFTER STATEMENT
DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT
PAID HERE \$

MAKE CHECKS PAYABLE / REMIT TO:

Foothills Sports Med & Rehab Scottsdal
15410 S MOUNTAIN PKWY STE 112
PHOENIX AZ 85044-6691



☐ Please check box if above address is incorrect or insurance
information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH
YOUR PAYMENT IN ENCLOSED ENVELOPE

Date	Provider	Location	Charges	Payments/ Adjustments	Balance
07/02/2019	Stohr	Scottsdale FSD	402.00	-65.00	337.00
Patient Payments					
Date	Description	Amount			
07/02/2019	CREDIT CARD	\$65.00			

AMOUNT DUE

\$337.00