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: ☐ AUTO ACCIDENT ☐ WORKER'S COMPENSATION		Date of Injury

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

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN OR PROVIDER'S FEE

HOSPITAL CHARGES OR OTHER FACILITY

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your other physicians or providers.

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

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ 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 $

Stmt ID#: 1097555180

150594 - 860

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

0037 001575

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

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

150594-860-12113868