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CHARLES RICHARDSON  
815 SW 10TH ST  
GAINESVILLE, FL 32601-7826

701

### Account Summary

Guarantor Account Number	<b>103137618</b>
Responsible Party	Charles Richardson
Patient Name	Charles Richardson
Hospital Amount Due	\$240.00
Physician Amount Due	\$85.49
<b>Amount Due</b>	<b>\$325.49</b>
<b>Minimum Amount Due by 06/29/22</b>	<b>\$325.49</b>

### Current Insurance on File

Our records show the following insurance information on file. If your insurance information has changed, please indicate your changes on the reverse side of the payment form.

Please tear off bottom portion and return with your payment

### Make Checks Payable to:

UF Health  
PO Box 16051  
Lewiston, ME 04243-9534

## Statement of Hospital Services and Physician Services

As of June 1, 2022

*Thank you for choosing UF Health  
for your healthcare needs*

**Save Time! Pay Online!**

**MyUFHealth-Patient Portal**



Sign up or log in to go paperless.  
Manage your health online at

**UFHealth.org/mychart**

**Go Green!! It's Simple and Secure.**

**Paying Your Bill:** For your convenience, we have three (3) options available.

- **Online:** Pay your bill online at [UFHealth.org/mychart](https://ufhealth.org/mychart)
- **Mail:** Pay your bill by mailing your payment with the bottom portion of your bill.
- **Call:** Pay your bill over the phone at **(352) 265-7906** or **(888) 766-8154** Monday-Thursday 8:00am-8:00pm, Friday 8:00am-5:00pm and Saturday 9:00am-1:00pm EST.

**Please pay your bill in full for \$325.49 by 06/29/22.**

**Financial Assistance:** If you are uninsured or need help paying your medical bills please contact our Customer Service Department at **(352) 265-7906**, or toll free at **(888) 766-8154** or visit <https://ufhealth.org/financial-assistance>

### Billing Questions or Changes in Insurance

If you have any questions regarding the bill you have received from UFHealth, you can reach a customer service representative by emailing us using the patient portal at [UFHealth.org/mychart](https://ufhealth.org/mychart). Customer Service Representatives are available Monday-Thursday 8:00am-8:00pm, Friday 8:00am-5:00pm and Saturday 9:00am-1:00pm EST.

Answers to commonly asked billing questions can also be found online at <https://ufhealth.org/billing-and-insurance-faq>.

**Please See Reverse Side for Account Detail**

Responsible Party	Guarantor Account Number	Date Due
<b>Charles Richardson</b>	<b>103137618</b>	<b>06/29/22</b>
Total Amount Due		
<b>\$325.49</b>		

☐ Check here if your address or insurance has changed. Please make corrections and return with your payment or email a customer service representative via [UFHealth.org/mychart](https://ufhealth.org/mychart)



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

Signature \_\_\_\_\_

Expiration Date \_\_\_\_\_ CVV Code: \_\_\_\_\_

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# Statement of Hospital Services and Physician Services

(As of June 1, 2022)

Account # 103137618 - Charles Richardson

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Date of Service	Provider	Description of Services	Charge	Adjustments	Insurance Payments	Patient Payments	Amount You Owe
Previous Activity							
03/28/22		HAR # 2006001360	\$460.00	\$-220.00	\$0.00	\$0.00	\$240.00
03/28/22		HAR # 8037368072	\$61.00	\$-40.51	\$0.00	\$0.00	\$20.49
03/28/22		HAR # 8037392010	\$400.00	\$-218.32	\$-116.68	\$0.00	\$65.00
TOTAL			\$921.00	-\$478.83	-\$116.68	\$0.00	\$325.49

Hospital Balance	Professional Balance	Total Balance
\$240.00	\$85.49	\$325.49

## IMPORTANT MESSAGES

As of the above date we have not received payment in full on your account. If payment has been made, or your check is in the mail, please accept our thanks. If payment has not been made, payment is necessary to bring your account current. You can make your payment online using our patient portal at [UFHealth.org/mychart](https://UFHealth.org/mychart) or send a message to our Customer Service Department.

## RESPONSIBLE PARTY UPDATES/CHANGES

ACCOUNT NUMBER <b>103137618</b>	RESPONSIBLE PARTY <b>Charles Richardson</b>								
STREET ADDRESS, APT #		HOME PHONE NUMBER	CELL PHONE NUMBER						
CITY		STATE / PROVINCE	POSTAL CODE	COUNTRY					
INSURANCE CHANGES - PRIMARY					INSURANCE CHANGES - SECONDARY				
INSURANCE COMPANY			RELATIONSHIP TO SUBSCRIBER		INSURANCE COMPANY			RELATIONSHIP TO SUBSCRIBER	
SUBSCRIBER'S NAME			SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S NAME			SUBSCRIBER'S DATE OF BIRTH	
I.D. NUMBER		GROUP/PLAN NUMBER	EFFECTIVE DATE		I.D. NUMBER		GROUP/PLAN NUMBER	EFFECTIVE DATE	
MAILING ADDRESS FOR CLAIMS					MAILING ADDRESS FOR CLAIMS				
CITY			STATE	ZIP CODE	CITY			STATE	ZIP CODE
INSURANCE PHONE NUMBER					INSURANCE PHONE NUMBER				

\*\*\* IF POSSIBLE, PLEASE ENCLOSE A COPY OF YOUR INSURANCE ID CARD (FRONT AND BACK) WITH THIS CHANGE \*\*\*