


**CONTRA COSTA
ONCOLOGY**
Patient Account

Patient Nikolai Schlegel
 Statement Date 04/30/2023
 Patient Account # 18411

CONTRA COSTA ONCOLOGY
 500 Lennon Lane
 Walnut Creek, CA 94598

MESSAGE:

DATE	DESCRIPTION	CHARGES	PAYMENTS & ADJUSTMENTS	PATIENT RESPONSIBILITY
	Patient Name: Nikolai Schlegel			
01/23/2023	99443 - Telephone evaluation and management se	80.00		0.00
02/02/2023	Payment Check United Health Care		0.00	0.00
02/02/2023	Adjustment		20.05	20.05
04/12/2023	Adjustment		59.95	59.95
04/12/2023	Adjustment			
02/27/2023	99215 - Office or other outpatient visit for t	310.00		23.19
03/13/2023	Payment Check United Health Care		208.70	
03/13/2023	Adjustment		78.11	

Page 1 of 1

▲ Keep top portion for your records ▲

▼ Mail bottom portion with mailed payments ▼

Billing Summary

Patient Nikolai Schlegel
 Statement Date 04/30/2023
 Patient Account # 18411

PATIENT RESPONSIBILITY \$23.19	ONLINE BILL PAY CODE 6G9FNB	PAYMENT DUE DATE 05/20/2023
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To pay by mail, make checks payable to

CONTRA COSTA ONCOLOGY
 500 LENNON LN
 WALNUT CREEK CA 94598-2415

FORWARDING SERVICE REQUESTED 0 0
 NIKOLAI SCHLEGE
 6 ELIZABETH LN
 DANVILLE, CA 94526-1547

34-10927
 11321987.2
 2218679


Pay Online
<https://mypay.poscorp.com/ContraCosta>
Online Bill Pay Code
6G9FNB
Patient Responsibility
\$23.19
Payment Due Date
05/20/2023

Billing Questions: (925) 939-9622

See reverse side for important billing information. ► ► ►





Pay Online

<https://mypay.poscorp.com/ContraCosta>
 Guest Pay or Register
 Sign up for eStatements,
 or set up a payment plan!

Pay by Phone

& Billing Questions
 (925) 939-9622
 Mon-Fri: 8:00am - 5:00pm

Pay by Mail

Checks payable to:
 Contra Costa Oncology
 500 Lennon Lane
 Walnut Creek, CA 94598

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or your responsibility as a patient.

How much do I really owe?

You are responsible for the amount listed in the box PATIENT RESPONSIBILITY. As every insurance plan is different, if you disagree with how your insurance paid on your account, please contact them prior to contacting our office.

What if I cannot pay in full?

Please call our patient account representatives or go online to set up a payment plan.

Co-Pay:

A dollar amount contracted between you and your insurance carrier, due at time of service.

Co-Insurance:

A percentage of the insurance benefits that you are responsible for.

Deductible:

A yearly dollar amount that you are responsible for based on the type of coverage you have selected with your insurance company.

Adjustment:

A contractual agreement that has been made between our Doctors and your insurance company.

PLEASE UPDATE ANY INFORMATION THAT HAS CHANGED SINCE YOUR LAST STATEMENT

IF PAYING BY CREDIT CARD, FILL OUT BELOW	
SEE FRONT FOR ACCEPTED CREDIT CARDS	CARD TYPE
CARD NUMBER	
SIGNATURE	
<input type="checkbox"/> PAYING BY CHECK, SHOW AMOUNT PAID HERE \$	
ADDRESS CORRECTION <small>* COMPLETE THIS SECTION IF YOUR ADDRESS ON REVERSE SIDE IS INCORRECT</small>	
NAME	
ADDRESS	
CITY	
STATE ZIP	

PRIMARY INSURANCE COMPANY NAME		
INSURANCE COMPANY'S ADDRESS		
CITY	STATE	ZIP
POLICY HOLDER NAME	HOLDER'S DOB	RELATIONSHIP TO INSURED
INSUREE'S ID NUMBER	GROUP PLAN NUMBER	
SECONDARY INSURANCE COMPANY NAME		
INSURANCE COMPANY'S ADDRESS		
CITY	STATE	ZIP
INSUREE'S ID NUMBER	GROUP PLAN NUMBER	

