



PO BOX 58538
Webster, TX 77598
281-694-5986

DONNA ALLISON
926 CHASE LOCK DR
BACLIFF, TX 77518-2460

(832)221-3047

| Statement Date | Invoice Number | Page |
|----------------|----------------|-------------|
| 02/10/2025 | CLS ALLDO006 | 1 |
| Guarantor | Due Date | Payment Due |
| DONNA ALLISON | Upon Receipt | 25.00 |

| Pay Online | |
|---|---|
| Go to: cls.health/payment or scan the QR Code |  |
| Make Checks Payable To: | |
| CLS HEALTH PLLC PO BOX 58538 Webster, TX 77598 | |

| | |
|----------------------------------|---------------------------------|
| Date of Last Payment: 11/14/2024 | Amount of Last Payment: -121.22 |
|----------------------------------|---------------------------------|

| | | | | |
|---------------------------|---|---------------------------|---------------------------------|------------------------------|
| Patient: DONNA ALLISON | Rendering Physician: ABDELNASER ELKHALILI MD | Chart Number: ALLDO006 | Place of Service: CLS HEALTH | Date of Birth: 07/06/1949 |
|---------------------------|---|---------------------------|---------------------------------|------------------------------|

| Dates | Procedure | Description | Modifier | Charge | Paid By Patient | Applied to Deductible | Paid by WELCARE | Adjustments | Remainder |
|----------|-----------|-------------|----------|--------|--------------------|--------------------------|--------------------|-------------|-----------|
| 01/17/24 | 99999 | NO SHOW | | 25.00 | | | 0.00 | | 25.00 |

| | | | | |
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|----------|-----------|---------------------------|----------|--------|--------------------|--------------------------|--------------------|-------------|-----------|
| 08/25/23 | 99213 | OFFICE VISIT EST/LEVEL 3 | 25 | 272.00 | -53.20 | | -51.99 | -180.01 | -13.20 |
| 08/25/23 | 96365 | Ther/proph/diag iv/infini | | 193.00 | | | -51.74 | -128.06 | 13.20 |

Have a question about your balance, or need to update your insurance information with us?

Call 281-694-5986

To make a payment online, go to cls.health/payment

If remitting payment via mail in check, Please include statement.

| Amount Due |
|------------|
| 25.00 |