Sample Hospital

CLINICARE

Health Care

UniDoc Medial Center
123 Main Street
Anywhere, NY 12345 - 6789

To Contact Us Call: 123 - 456 - 7890

Phone representatives are available:
8am to 8pm Monday - Thursday
and 8am to 4:30pm Friday

Guarantor Number:	2nnnnn
Guarantor Name:	Sample Guarantor
Statement Date:	01/02/2023
Due Date:	Upon Receipt

Date of Service	Description	Charges	Payment/Adjustments	Patient Balance
01/02/2023 to 01/02/2023	Visit #123 Sample Patient			
	Pharmacy	60.53		
	Treatment or Observation Room	588.00		
	Insurance Payment		-598.53	
	Total Hospital Charges	638.53		
	Total Payments		-598.53	
	Total Adjustments		0.0	
	Patient Due			**40.00**

MESSAGES:
We have filed the medical claims with your insurance.They have indicated the balance is your responsibility. To pay your DIN online, please visit www.ourwebsite.com.

If you have questions regarding your bill, or for payment arrangements, please call 123 - 456 - 78 or send an email inquiry to aboutmybill@ourwebsite.com

Current Balance	**$40.00**

This is your first notice for the visit above, which includes a list of itemized services rendered.

We offer a Financial Aid program for qualified applicants. For more information, please call 123-456-7890 or visit our website at www.ourwebsite.com for more information.

Please retain statement for your records

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

MAKE CHECKS PAYABLE TO
UniDoc Medial Center
123 Main Street
Anywhere, NY 12345 - 6789

CHANGE SERVICE REQUESTED
For Billing inquries: 123 - 456 - 7890
Patent Name: Sample Patent

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMEX, FILL OUT BELOW

Visa	**MasterCard**	**Discover**	**Amex**
Card Number		Exp. Date	Amount
Signature		SVV	

Statement Date	Guarantor number	Pay the Amount
01/02/2023	Sample Guarantor	$40.00
Visit # to apply payment		Show amount paid here

Sample Guarantor
123 MAIN STREET
ANYWHERE, NY 12345 - 6789

UniDoc Medial Center
123 Main Street
Anywhere, NY 12345 - 6789

The Sample Medical Center financial assistance policy plain language summary

Sample Medical Center offers financial assistance to eligible patients who are uninsured, underinsured, and ineligible for a government health care program, or who are otherwise unable to pay for medically necessary care based on their individual financial situation.
Patients seeking financial assistance must apply for the program, which is summarized below.

Eligible Services

Eligible services include emergent or medically necessary services provided by the Hospital. Eligible patients include all patients who submit a financial assistance application (including requested documentation) and are determined to be eligible for financial assistance by the Patient Financial Services Department.

How to Apply

Financial Assistance applications may be obtained/completed/submitted as follows:

- Obtain an application at The Sample Medical Center's Patient Financial Services Department located at Main Street 123
- Request to have an application by mail at: 123 Main Street, Anywhere, NY 12345 - 6789.
- Request to have an application mailed to you by calling 123 - 456 - 7890. Our hours of operation are: Monday-Friday, 8:30a.m.-4:30p.m.
- Download an application through the Sample Medical Center's website: https://www.ourwebsite.com/PatientFinancialServices.aspx

Patient Financial Service Counselors are available Monday through Friday, 8:30 a.m. to 4:30 pm via telephone (123) 456-7890 to address questions related to the Financial Assistance Program.
Please feel free to email us at:businessoffice@ourwebsite.com.

Section 1557 — Notice of Nondiscrimination

The Sample Medical Center complies with applicable Federal civil right laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If any of this following has changed since your last statement, please indicate...

About you:

Your name (Last, First, Middle initial)

Address

City | State | Zip

Telephone

Marital status **Single** **Married** **Separat.** **Divorced** **Widowed**

Employer's name | Telepohone

Employer's address

City | State | Zip

Comments:

About your insurance:

Primary insurance company's name | Effective date

Primary insurance company's address | Phone

City | State | Zip

Policyholder's ID number | Group plan number

Relationship to patient

Secondary insurance company's name | Effective date

Secondary insurance company's address | Phone

City | State | Zip

Policyholder's ID number | Group plan number

Relationship to patient