

UNC ROCKINGHAM HEALTH CARE
 PO BOX 151
 EDEN, NC 27289

JOHN DOE
 123 ANY STREET
 ANYPLACE, NC 27288-0000

IF PAYING BY CREDIT CARD, FILL OUT BELOW

<input type="checkbox"/> MASTERCARD <input checked="" type="checkbox"/> DISCOVER <input type="checkbox"/> VISA			
1	CARD NUMBER CVV2 CODE AMOUNT		
SIGNATURE			
EXP. DATE			
2	3	4	5
0	8	\$	00

PLEASE CHECK BOX FOR ADDRESS CHANGE, (INDICATE NEW ADDRESS ON REVERSE SIDE.)

UNC ROCKINGHAM HEALTH CARE
 PO BOX 151
 EDEN, NC 27289

B1168 4642511 2400

DUE FROM PATIENT ON 5/3/2018 \$203.53

1 / 2

Please return top portion with your payment

Statement Date 12/28/2017	9 Patient Name JOHN DOE	Account Number 123456	10 Date of Service 04/2017
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MESSAGES	DESCRIPTION
<p>Thank you for choosing us for your healthcare needs.</p> <p>The balance on this account is now due from you. Please remit payment in the enclosed envelope with the attached payment coupon. If we receive your payment by 1/10/2018, you are eligible for a 5% discount that will reduce the amount you owe to \$627.57. You must contact us at 800-513-2815 to take advantage of this special offer.</p> <p>You must contact us to include this balance with a current payment arrangement. If you have difficulty paying this bill, please call us to ask about financial assistance.</p> <p>Our records indicate that you did not request us to bill an insurance company for the services provided. If this is not correct, please contact us immediately.</p> <p>13 You may now pay your bill...</p> <ul style="list-style-type: none"> Online at www.medicalpayments.org/uncrockingham By Phone at 800-513-2815 M-Th: 8:30 am - 6 pm and Friday 8:30 am - 4:30 pm By Mail at the remit address 	<p>11</p> <p>EMERGENCY ROOM \$589.00 RADIOLOGY \$512.00 Total Charges \$1101.00</p> <p>14</p> <p>TOTAL CHARGES \$ 1,101.00 TOTAL PAYMENTS \$ 0.00 TOTAL ADJUSTMENTS \$ 440.40 DUE FROM PATIENT \$ 660.60</p> <p>Please write your account number on your check. Make checks payable to: UNC Rockingham Health Care PO BOX 151 EDEN, NC 27289</p> <p>Please Pay This Amount \$ 660.60</p>

KEY

- Information required if paying by credit or debit card.
- Patient's account number.
- Date this bill was mailed.
- Total amount due from you.
- Amount you are paying.
- Name and mailing address of the person responsible for paying this bill.
- Payment mailing address. Please mail your payment in the enclosed envelope, but do not include correspondence.
- Payment due date.
- Name of patient to whom services were provided.
- Time period during which services were provided.
- A summary of charges you received during your stay.
- Specific information about why you are receiving this bill.
- Instructions for paying your bill by phone or online.
- Total charges accumulated, payments applied towards account, and adjustments applied towards account.