STATEMENT OF ACCOUNT

STATEMENT DATE

ACCOUNT NUMBER	PATIENT NAME	STATEMENT PERIOD

AMOUNT DUE

MAIL PAYMENT TO

TO RECEIVE PROPER CREDIT, PLEASE RETURN THIS PORTION WITH YOUR PAYMENT
NOTE: SHOULD YOU WISH TO PAY BY CREDIT CARD, SEE AUTHORIZATION NOTICE ON THE BACK.

3½" Perf

SUMMARY OF ACCOUNT

STATEMENT DATE

STATEMENT PERIOD	PATIENT NAME	ACCOUNT NUMBER

THE INSURANCE CLAIMS OUTSTANDING REPRESENTS OUR ESTIMATE OF INSURANCE LIABILITY BASED ON OUR BEST INFORMATION

ACCOUNT BALANCE LAST STATEMENT	NEW CHARGES OR ADJUSTMENTS	NEW PAYMENTS OR CREDITS	NEW ACCOUNT ADJUSTMENTS	INSURANCE CLAIMS OUTSTANDING

AMOUNT DUE

DATE	DESCRIPTION	UNITS	AMOUNT	DATE	DESCRIPTION	UNITS	AMOUNT

THIS BILL IS FOR HOSPITAL SERVICES ONLY
PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

McKesson Corp. #3304 HCA LOUISIANA / INDIANA BILL (12/03)

PAYMENT BY CREDIT CARD AUTHORIZATION FORM

CHECK ONLY ONE:

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

CREDIT CARD NUMBER

EXP. DATE

AUTHORIZED SIGNATURE ______________________ TOTAL $ __________

CARDMEMBER'S NAME ______________________

PLEASE NOTE THAT THIS FORM SHOULD BE COMPLETED ONLY WHEN YOU WISH TO PAY YOUR HOSPITAL BILL BY CREDIT CARD.

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* * * * EXPLANATION * * * *

STATEMENT OF ACCOUNT

SEE HOSPITAL ADDRESS ON FRONT OF STATEMENT (7)

PAGE 1 OF 1

STATEMENT DATE (4)

ACCOUNT NUMBER	PATIENT NAME	STATEMENT PERIOD	AMOUNT DUE
(1)	(2)	(3)	(5)

(6) *SEE FRONT OF STATEMENT*

MAIL PAYMENT TO

SEE HOSPITAL ADDRESS ON FRONT OF STATEMENT (7)

(8) TO RECEIVE PROPER CREDIT, PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.
NOTE: SHOULD YOU WISH TO PAY BY CREDIT CARD, SEE AUTHORIZATION NOTICE ON THE BACK.

SUMMARY OF ACCOUNT

SEE HOSPITAL ADDRESS ON FRONT OF STATEMENT (7)

STATEMENT DATE (4)

STATEMENT PERIOD	PATIENT NAME	ACCOUNT NUMBER
(3)	(2)	(1)

THE INSURANCE CLAIMS OUTSTANDING REPRESENTS OUR ESTIMATE OF INSURANCE LIABILITY BASED ON OUR BEST INFORMATION

ACCOUNT BALANCE LAST STATEMENT	NEW CHARGES OR ADJUSTMENTS	NEW PAYMENTS OR CREDITS	NEW ACCOUNT ADJUSTMENTS	INSURANCE CLAIMS OUTSTANDING	AMOUNT DUE
(9)	(10)	(11)	(12)	(13)	(5)

DATE	DESCRIPTION	UNITS	AMOUNT	DATE	DESCRIPTION	UNITS	AMOUNT
(14)	(15)	(16)	(17)				
(18)							

(19) *IF YOU HAVE QUESTIONS REGARDING YOUR ACCOUNT, PLEASE CALL:*
(20) Message from hospital

THIS BILL IS FOR HOSPITAL SERVICES ONLY
PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

* * * * EXPLANATION * * * *

1. Patient's account number
2. Patient's name
3. Period of time covered by this statement
4. Date that the statement was printed
5. Amount now due from the patient
6. Name and address of the person responsible for payment of the account
7. Please make check payable to the hospital and mail payment using the enclosed envelope
8. Payment information and instructions for using your credit card
9. Account balance reported on your previous statement. This is the first statement if the amount is 0.00
10. New charges added or adjustments made since your last statement
11. New payments or credits made since your last statement
12. New adjustments since your last statement
13. Insurance claims outstanding
14. Date of the hospital service, payment, or message
15. Description of the hospital service, payment information, or message
16. Service amount in units
17. Charge, payment or visit amount
18. Specific information concerning your account
19. Telephone number to call regarding your account
20. Message information from your hospital