

Monthly Statement



SCOTT & WHITE

P.O. Box 6125
Temple, Texas 76503-6125
(254) 724-8800

John Doe
800 S. 5th Street
Temple, TX 76502-1353

Account Number: 3682

The Children's Miracle Network Annual Marathon Fundraiser will be held soon. Please consider making a donation this year.

Statement Summary as of 08-03-99

Previous Account Balance:	\$914.00
Your payments since previous billing date:	- \$60.00
Insurance payments or adjustments since previous billing date:	- \$133.00
Total new charges:	+ \$823.84
Current Account Balance:	\$1,544.84
Amount pending with your insurance company:	- \$1,234.84
Amount You Now Owe:	\$310.00

Please note:

1. You are responsible for paying \$ **310.00** to SCOTT & WHITE by **09/15/1999**.
2. Charges of \$ **1,234.84** are pending with your insurance company. If your insurance company made payment (s) to SCOTT & WHITE or denied a claim since your last statement, that left \$ **0.00** for you to pay. This amount was added to the "Amount You Now Owe."
3. SCOTT & WHITE refiled charges of \$ **0.00** with your insurance company since your last statement. This amount has been taken out of the "Amount You Now Owe."

For billing questions, please call (254) 724-8800 or (800) 749-3898.

Responsible Party:	John Doe
Account Number:	3682
Amount Due:	\$310.00
Due Date:	09/15/99
Amount Enclosed:	\$ <input type="text"/>

Method of payment:

Check Money Order Credit Card

Check Card Used For Payment	
<input type="checkbox"/> Visa	<input type="checkbox"/> Master Card <input type="checkbox"/> Discover <input type="checkbox"/> American Express
Card Number	Amount
Signature	Expiration Date



SCOTT & WHITE
P.O. BOX 6125
TEMPLE TX 76503-6125



JOHN DOE
800 S 5TH STREET
TEMPLE TX 76502-1353

Please detach and return with your payment. Please make check or money order payable to **Scott and White**. Be sure to include your account number on your check or money order. Never send cash through the mail. Thank you for your payment.

Address or insurance change? Please check here and record changes on the back of this statement.

Monthly Statement



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John Doe
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 Temple, TX 76502-1353

Account Number: 3682

Account Detail from 07-02-99 to 08-03-99

Page 2 of 2

Patient Name	Date of Activity or Service	Account Activity	Description of Service	Charges	Payments or Adjustments
***** Scott & White Hospital *****					
Doe, Jane	07/02/99		IV .9ns 1000cc DSG Small DSG Tegaderm Adult Cath IV Insyte Pelvis X-Ray, Complete, Minimum Ankle X-Ray, Complete, Minimum 3 Hip X-Ray, Complete, Minimum 2 Knee X-Ray, Complete, Four or More Tibia & Fibula X-Ray, Ap & Lat ECG: Routine w/Interpretation	43.50 2.75 4.00 7.00 99.54 83.44 80.78 96.43 76.08 112.42	
Doe, Jane	07/03/99		Ankle X-Ray, Ap & Lat	74.90	
***** Scott & White Clinic *****					
Doe, Jane	07/20/99	Orthopedics	Splint, Ambulatory	143.00	
Doe, Jane	07/21/99	SWHP Payment/Adjustment			133.00
***** Personal Payments Received *****					
Doe, John	07/07/99	Personal Pmt			50.00
Doe, Jane	07/20/99	Personal Pmt-SWHP Copay			10.00
Please note: This is the only time you will see this detail for your charges.				\$823.84	\$193.00

If you need a more detailed explanation, please call (254) 724-8800 or (800) 749-3898.

Scott and White has billed \$1,234.84 to your insurance company. Scott and White is waiting for your insurance company to pay all or a portion of these charges. Your insurance company pays based on your particular plan benefits. You should consult your Explanation of Benefits for clarification on the payments your insurance company applied to specific charges. After Scott and White receives payment from your insurance company, the remaining balance is your responsibility.

Patient's Name	Mayo Clinic Number	Visit Number	Dates of Service
MR JOHN DOE	1-234-567	2800	01/02/02 - 01/03/02

Please refer to patient's name, Mayo Clinic number and visit number on all correspondence.

Billing Account Number: 1-234-567

Statement Date: January 21, 2002

Addressee

MR JOHN DOE
520 PLEASANT STREET
ANYTOWN, MN 09876

Services Provided By

MAYO CLINIC ROCHESTER
200 FIRST STREET SW
ROCHESTER, MN 55905

THIS IS NOT A BILL – THIS IS FOR YOUR INFORMATION ONLY

Important Information to Assist You

1. This Itemized Statement of Charges is for your information only. You will be receiving a Monthly Statement of Account (your bill) reflecting your financial responsibility. The visit number above will help you identify this specific visit on your Monthly Statement of Account.
2. Please review this statement carefully. If you have questions, please contact Patient Account Services:

Mayo Clinic
RO-HA-04-ACCT
200 First Street SW
Rochester, MN 55905

Telephone 507-287-1838
8:00 AM to 5:00 PM CST
Monday through Friday

3. We have generated a claim for the following insurance company(ies):
ABC Insurance

**** Verify the insurance is correct and notify us of any changes ****

4. Retain this Itemized Statement of Charges for your records.

MR JOHN DOE
 520 PLEASANT STREET
 ANYTOWN, MN 09876

 Billing Account Number: 1-234-567
 Statement Date: February 4, 2002
 Customer Service: **507-287-1819**
Messages:
Thank you for choosing Mayo Clinic.

Thank you for your payment.

You are currently responsible for paying \$65.85 to Mayo Clinic.

PLEASE NOTE: Charges totaling \$804.69 are pending with your insurance. You will be responsible for the portion not covered. If you have questions about insurance claims or payments, contact your insurance representative.

Account Summary:

Previous Account Balance as of 01/04/02	\$	353.23
New Charges	\$	804.69
Payment/Adjustments	\$	287.38
Current Account Balance	\$	870.54
Insurance Claims Pending	\$	804.69
CURRENT AMOUNT DUE:	\$	65.85

 To help us process your payment, **please return the lower portion of this statement** with your payment. Do not send currency.

Billing Addressee	Billing Account Number	Date Due	Amount Due	Amount Enclosed
DOE, JOHN	1-234-567	Upon Receipt	\$ 65.85	

 Check here if your address has changed. Please indicate changes on back.

To pay by check or money order:

 Make payable to MAYO CLINIC. Write your **billing account number** on the front of your check or money order and mail in the enclosed envelope to:

**MAYO CLINIC
 P.O. BOX 4003
 ROCHESTER, MN 55903-4003**
To pay by credit/debit card:

Please indicate credit/debit card preference. Provide the account information and sign below, or call 507-287-1819.

- | | | |
|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Visa | <input type="checkbox"/> Mastercard | <input type="checkbox"/> Discover |
| <input type="checkbox"/> American Express | <input type="checkbox"/> Diners Club | |

Card Account No.: _____

Card Holder Name: _____

Authorized Signature: _____

Expiration Date: _____ Amount: _____



Patient Name Mayo Clinic Number/Visit Number Dates of Service Place of Service Transaction Detail/Description	Account Activity	Insurance Claims Pending	Personal Responsibility
DOE, JOHN 1-234-567 Visit 9876 03/08/2001 - 03/08/2001 St. Marys Hospital			
Previous Balance 11/19/01 Personal Payment	\$ 37.38 \$ 37.38-		
	Visit Balance Insurance Pending Amount Due	\$ 0.00	\$ 0.00
DOE, JOHN 1-234-567 Visit 9873 03/06/2001 - 03/08/2001 Mayo Clinic Rochester			
Previous Balance 11/19/01 ABC Insurance payment	\$ 315.85 \$ 250.00		
	Visit Balance Insurance Pending Amount Due	\$ 0.00	\$ 65.85
DOE, JANE 2-345-678 Visit 9875 11/18/2001 - 11/18/2001 Rochester Methodist Hospital			
New Charges 11/27/01 Insurance Claim Filed/ABC Insurance	\$ 286.40		
	Visit Balance Insurance Pending Amount Due	\$ 286.40	\$ 0.00
DOE, JANE 2-345-678 Visit 9874 11/18/2001 - 11/19/2001 Mayo Clinic Rochester			
New Charges 11/22/01 Insurance Claim Filed/ABC Insurance	\$ 518.29		
	Visit Balance Insurance Pending Amount Due	\$ 518.29	\$ 0.00
	Current Account Balance Insurance Claims Pending Current Amount Due	\$ 870.54 \$ 804.69	\$ 65.85

Payment Policy

- Even though you may have insurance, you are responsible for payment of your Mayo Clinic accounts. You will receive a statement each month your account has a balance.
- If payment is not received for any claims pending with your insurance company within 45 days, we will look to you for full payment.

Billing Inquiries

Please review this statement carefully. We welcome any questions you may have about your account, and invite you to contact Patient Account Services by telephone, Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, or by letter. We will make every attempt to answer your questions concerning your account.

Patient Account Services
Mayo Clinic
RO-HA-04-ACCT
200 First Street SW
Rochester, MN 55905
Telephone 507-287-1819

For international billing inquiries:
International Financial Services
Mayo Clinic
200 First Street SW
Rochester, MN 55905
Telephone 507-284-5063

Glossary of Terms

Adjustments: A credit or debit transaction applied to the account.

Billing Account Number: The account number of the person assigned to receive the bill. Refer to this number when contacting Mayo Clinic with questions.

Billing Addressee: The person designated to receive the monthly billing statements. This person can coordinate the billing, payment and insurance coverage for the account.

Contract Adjustment: A credit or debit applied to the account due to the contractual agreement between Mayo Clinic and the insurance company.

Insurance Claims Pending: Charges filed to insurance company; Mayo Clinic has not received a determination of the benefits.

Mayo Clinic Number: The patient's personal identification number.

New Charges: Charges billed by Mayo Clinic since the previous monthly statement. These are detailed on your Itemized Statement of Charges.

Visit Balance: The current balance of each episode of care.

Visit Number: A number assigned to identify each episode of care. The number is used to track services and payments.

Address/Telephone Change

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____