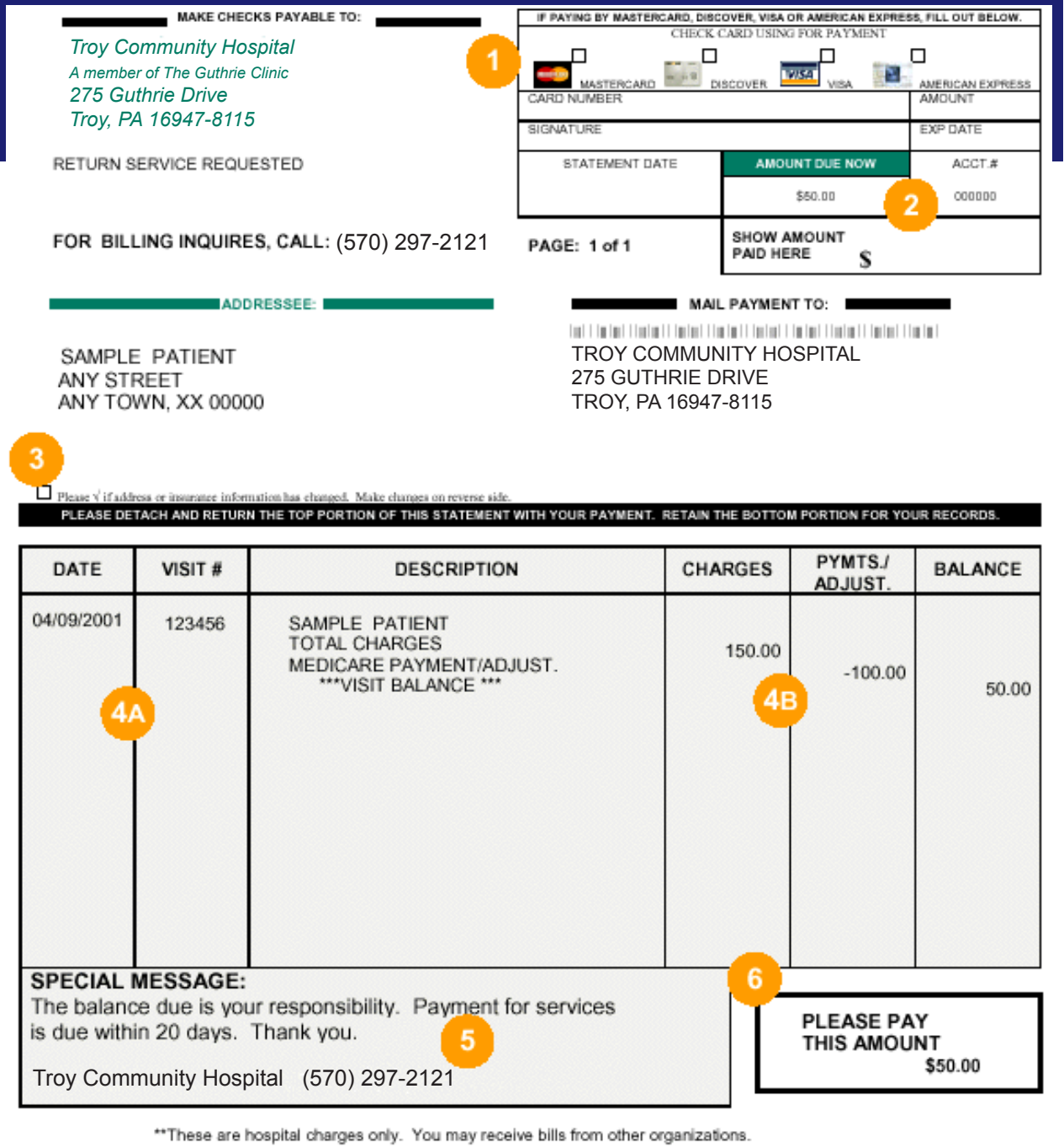
Understanding Your New Billing Statement



MAKE CHECKS PAYABLE TO:

Troy Community Hospital
A member of The Guthrie Clinic
275 Guthrie Drive
Troy, PA 16947-8115

RETURN SERVICE REQUESTED

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT
MASTERCARD DISCOVER VISA AMERICAN EXPRESS
CARD NUMBER | AMOUNT
SIGNATURE | EXP DATE
STATEMENT DATE | AMOUNT DUE NOW | ACCT.#
$50.00 | 000000

FOR BILLING INQUIRES, CALL: (570) 297-2121

PAGE: 1 of 1

SHOW AMOUNT PAID HERE $

ADDRESSEE:

SAMPLE PATIENT
ANY STREET
ANY TOWN, XX 00000

MAIL PAYMENT TO:

TROY COMMUNITY HOSPITAL
275 GUTHRIE DRIVE
TROY, PA 16947-8115

Please √ if address or insurance information has changed. Make changes on reverse side.

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	VISIT #	DESCRIPTION	CHARGES	PYMTS./ ADJUST.	BALANCE
04/09/2001	123456	SAMPLE PATIENT TOTAL CHARGES MEDICARE PAYMENT/ADJUST. ***VISIT BALANCE ***	150.00	-100.00	50.00

SPECIAL MESSAGE:
The balance due is your responsibility. Payment for services is due within 20 days. Thank you.

Troy Community Hospital (570) 297-2121

PLEASE PAY THIS AMOUNT $50.00

**These are hospital charges only. You may receive bills from other organizations.

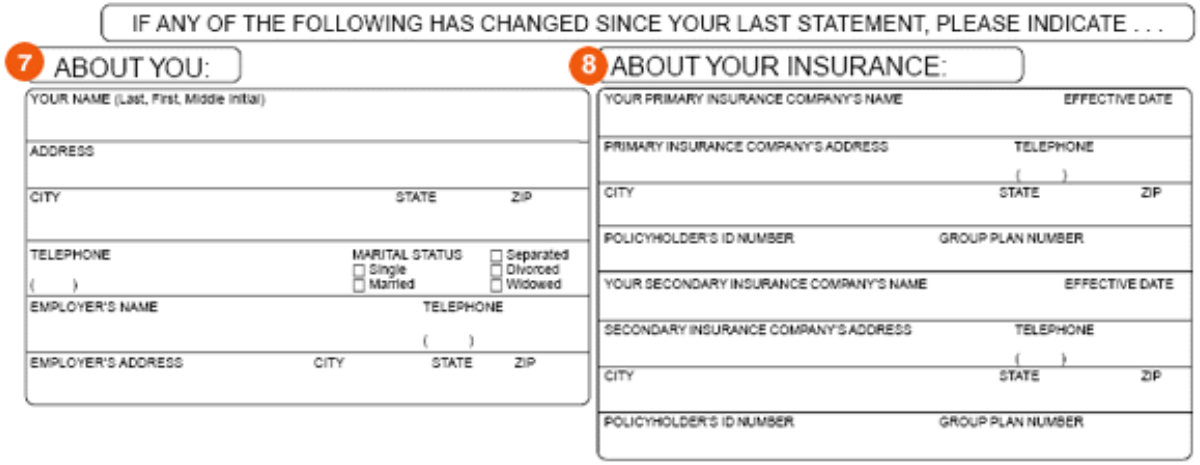
1. **Payment Options/Information.** This section of your statement lets you know the amount due for this account and gives options for making your payment. We accept personal checks, Master Card, Visa, Discover and American Express. For your convenience your credit card information can be entered here, along with your signature, and mailed to us for payment on your account balance. If making payment in person please bring this portion of your statement with you. If mailing your payment please use the envelope enclosed.
2. **Account Number.** A unique identification number that identifies the individual or individuals who have received the services detailed below. To help us better serve you, please use this number when writing or calling us.
3. **Address and Insurance Changes.** On the reverse side of this portion of your bill is an area for you to write updated address information and to review the insurance information we have on file for you. If you complete the address piece and return this portion to us, we will update our files. After reviewing the insurance information, if any update is needed, you can make a note in the insurance information box or call our Patient Representatives to assist you.
4A. **Visit Information.** This section details visit information for the patient who received services within Robert Packer Hospital. The visit information includes the visit number, the date the visit occurred, and the name of the patient who received the service.
4B. **Visit Information Charges, Payments, and Adjustments.** The information contained in these boxes may include charge, payment, and adjustment activity associated with the services directly to the left. The payments and/or denials received from your insurance company will be itemized for you here. Payments received from you will also be itemized in this box until the balance is zero.
5. **Important Account Information.** Each time you receive a statement from us this box will contain messages that let you know the status of the account balance.
6. **Outstanding Account Amount Due.** The amount shown in this box is an accumulative figure for the account balance due on all items detailed on this statement.

GUTHRIE

Understanding Your New Billing Statement

7 **About You.** This section of your statement lets you make corrections to your demographic information.

8 **About Your Insurance.** This section of your statement lets you make corrections to your insurance information.


IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . .

7 ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE ( ) MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME TELEPHONE ( )

EMPLOYER'S ADDRESS CITY STATE ZIP

8 ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS TELEPHONE ( )

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS TELEPHONE ( )

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

PAY YOUR BILL OR CHANGE PATIENT INFORMATION ON OUR WEBSITE AT:
www.guthrie.org/patientcentral

The Guthrie Clinic is proud of its mission to provide quality care to all who need it. If you do not have insurance or worry that you may not be able to pay part or all of your care, we may be able to help. The Guthrie Clinic provides financial aid to patients based on their income, assets, and financial needs. In addition, we may be able to help you get free or low-cost health insurance or wotk with you to arrange a manageable payment plan.

Federal and state laws require all hospital/clinics to seek payment for care provided. This means we could ultimately turn unpaid bills over to a collection agency, which could affect your credit status. Therefore, it is important that you let us know if there may be a problem paying your bill.

GUTHRIE