|  |
| --- |
| TOTAL AMOUNT CURRENTLY DUE (All Accounts) |
| $100.00 |

|  |  |
| --- | --- |
| **Statement date:** | 04/30/22 |
| **Responsible Party:** | Patient Name |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **PAST DUE** | **FINAL NOTICE** |
| 0-30 | 31-60 | 61-90 | 91-120 | 121+ |
| $100.00 |

|  |  |
| --- | --- |
| **AMOUNT DUE**$100 | **DUE DATE**NOW |

**FINAL NOTICE FOR ONE OR MORE OUTSTANDING ACCOUNTS**

The amount referenced above remains unpaid and is due now. Please pay the amount due or make arrangements to pay this balance within the next 30 days. Failure to pay or contact us will result in your account being placed for collections.

If you do not pay or make arrangements to pay this balance by 6/5/22, we will be transferring your account to A-Ok Enterprises. We will provide A-OK Enterprises with the following email address for you joepatient@gmail.com. A-OK Enterprises may use this email address to communicate with you about this debt. If others have access to this email address, it is possible they may see the emails sent by A-OK Enterprises. If you would like to opt-out of email communications by A-Ok Enterprises, please notify us at PFS@XYZHospital.com. You may also sign the box below and return the form to us by 6/1/22 so that we may remove your email address as a means of communication for this account.

**Financial Assistance Information**

Financial Assistance may be available if you are uninsured or have exhausted your insurance benefits and cannot afford to pay your bill. Please visit www.XYZHospital.com or contact Customer Service at 970-555-5555 for information about XYZ’s Financial Assistance Policy.

**Enroll in paperless statements!**

*You may receive separate bills from additional providers who assisted with your care.*

Pay your bill or setup a payment plan outline at www.XYZhospital.com

For assistance, please call Patient Financial Services at 970-555-5555 or 833-555-5555

Between 7:30AM – 5PM, Monday – Friday

**Thank you for choosing XYZ Hospital for your health care needs.**

Please return BOTTOM portion in supplied envelope.

XYZ Hospital

PO Box 1234

Anywhere, CO 80001

Return mail processing center

o Please check box and make address or insurance changes on the reverse side

Patient Name

1 Main St.

Anywhere, CO 80001-0000

|  |
| --- |
| **Please complete this form if you wish to OPT OUT of email communication.** |
| Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By entering my name and email address above, and sending this back to XYZ hospital, I hereby opt-out of email communications by A-OK enterprises with me at the email address written above.  |

­­­

|  |
| --- |
| **Make checks payable and remit to:** |
| XYZ HospitalPO Box 1234Anywhere, CO 80001 |

|  |
| --- |
| **Pay your bill online and set up paperless statements** |
| www.xyzhospital.com |

|  |
| --- |
|  |
| CARD NUMBER # | V-CODE (3 digit code on back of card) |
| SIGNATURE | EXP DATE |
| STATEMENT DATE«Insert18» | SHOW AMOUNT PAID HERE | ACCT #«Insert19» |

**IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW**



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PatientLocationPrimary insurance | Provider nameDate of serviceSecondary insurance | EncounterTotal charges | InsurancePaymentsAdjustments | Patient payments | Total balance |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |