

**Statement**

<b>PATIENT NAME</b> [REDACTED]			<b>IF PAYING BY CREDIT, FILL OUT BELOW. CHECK CARD USED</b> <input type="checkbox"/> MASTER CARD <input type="checkbox"/> VISA <input type="checkbox"/> DISCOVER	
<b>BILL DATE</b> 04/21/2021	<b>ACCT</b> [REDACTED]	<b>AMOUNT PAID</b>	<b>CARD NUMBER</b>	<b>AMOUNT PAID</b>
			<b>SIGNATURE:</b>	<b>EXP. DATE:</b>
			<b>AMOUNT ENCLOSED:</b>	
[REDACTED]			<b>THIS IS A STATEMENT OF SERVICES RENDERED BY PHYSICIAN(S) WHO ARE MEMBERS OF:</b> [REDACTED]	

DATE OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT
11/20/2019	[REDACTED]	
11/20/2019	HG A1C LEVEL LT 7.0%	80.00
	Your Balance Due On These Services ...	80.00
04/21/2021	**** Make a secure online payment at <a href="https://healowpay.com">https://healowpay.com</a> by using your personal statement code - nyyCvLmy ****	

DATE	PATIENT NAME	ACCT. NO.	PAY THIS AMOUNT		
04/21/2021	[REDACTED]	[REDACTED]			80.00
<b>CURRENT</b>	<b>30 DAYS</b>	<b>60 DAYS</b>	<b>90 DAYS</b>	<b>120+ DAYS</b>	
0.00	0.00	0.00	0.00	80.00	

This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services. **MAKE CHECK PAYABLE TO:** [REDACTED]

**IMPORTANT MESSAGE REGARDING YOUR ACCOUNT**