STATEMENT

THIS IS A STATEMENT OF SERVICES RENDERED BY PHYSICIAN(S) WHO ARE MEMBERS OF:
Center For Adult Healthcare SC 303 East Army Trail Road Suite 301 Bloomingdale, IL60108-2169 630-893-0347

PATIENT NAME		
AUpgrade Test		
BILL DATE	ACCOUNT NO.	AMOUNT PAID
04/03/2015	12270	

Claim Number

AUpgrade Test
1111 Cornerway Street
Georgia AR 60506

This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services.

DATE OF SERVICE	DESCRIPTION OF SERVICE		AMOUNT
03/16/2014	Claim:9230, Provider: Mandeep Kohli, DO		
03/16/2014	Facility: Center For Adult Healthcare SC		
03/16/2014	AUDITOR EVOKE POTENT, COMPRE	100.00	
	Your Balance Due On These Services...		100.00

Patient Lastname, Firstname

Patient Account Number

Payment Amount To Pay

DATE	PATIENT NAME	ACCOUNT NO.	PAY THIS AMOUNT
04/03/2015	AUpgrade Test	12270	$100.00

MAKE CHECK PAYABLE TO : Center for Adult Healthcare SC

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

We are pleased to offer you the option of credit card payment. Please indicate your method below.

Payment Method: VISA MASTER CARD DISCOVER AMEX CHECK

Amount: ____________ Exp. Date: ____________

Credit Card No: ____________ Date: ____________

Signature: ____________ CVV: ____________