Guide to Understanding Your Statement

Credit card payment information area

Guarantor Name & Address

Person responsible for payment

Patient Name

Address correction box *(please indicate corrections on the back of this payment stub)*

Account Detail Area

Account message

Account Number

Payment Amount Due

Date of Service

Payment Amount Due

CASCADE VALLEY

Cascade Valley Hospital and Clinics
330 S Stillaguamish Avenue
Arlington, WA 98223
(360)618-7620 Fax (360)618-7662

ADDRESS SERVICE REQUESTED

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW

VISA / MasterCard

CARD NUMBER		AMOUNT
SIGNATURE		EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT	ACCT #
1/1/2013	195.50	V12345678
	AMOUNT PAID $	

Please note: If no amount is indicated above, your card will be charged the entire amount due.

ADDRESSEE:

JOHNATHON DOE
123 MAIN ST
AMERICA WA 98223

99999
99999
99999

11999990

Cascade Valley Hospital & Clinics
330 S Stillaguamish Ave
Arlington WA 98223

PLEASE CHECK BOX IF ADDRESS OR OTHER INFORMATION HAS CHANGED, AND INDICATE CHANGE(S) ON REVERSE SIDE.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

Patient Name	Account Number	Date of Service
JOHNATHON DOE	V12345678	01/01/13

Date	Description	Balance
10/14/13	LOWER EXT ANY JOINT W/O LEFT	2371.00
12/02/13	ADJ BHP COMMUNITY HEALTH	-1719.33
12/02/13	PAYMENT BHP COMMUNITY HEALTH	-456.17
	Charges to date:	2371.00
	Receipts to date:	456.17
	Adjustments to date:	1719.33

Your insurance has responded and the balance is now your responsibility for payment. If you need to discuss your account with us or ask about financial assistance, please call (360) 618-7620. Thank you.

Total Charges	Estimated Balance Due From Insurance	Total Due
2371.00	-2175.50	195.50

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