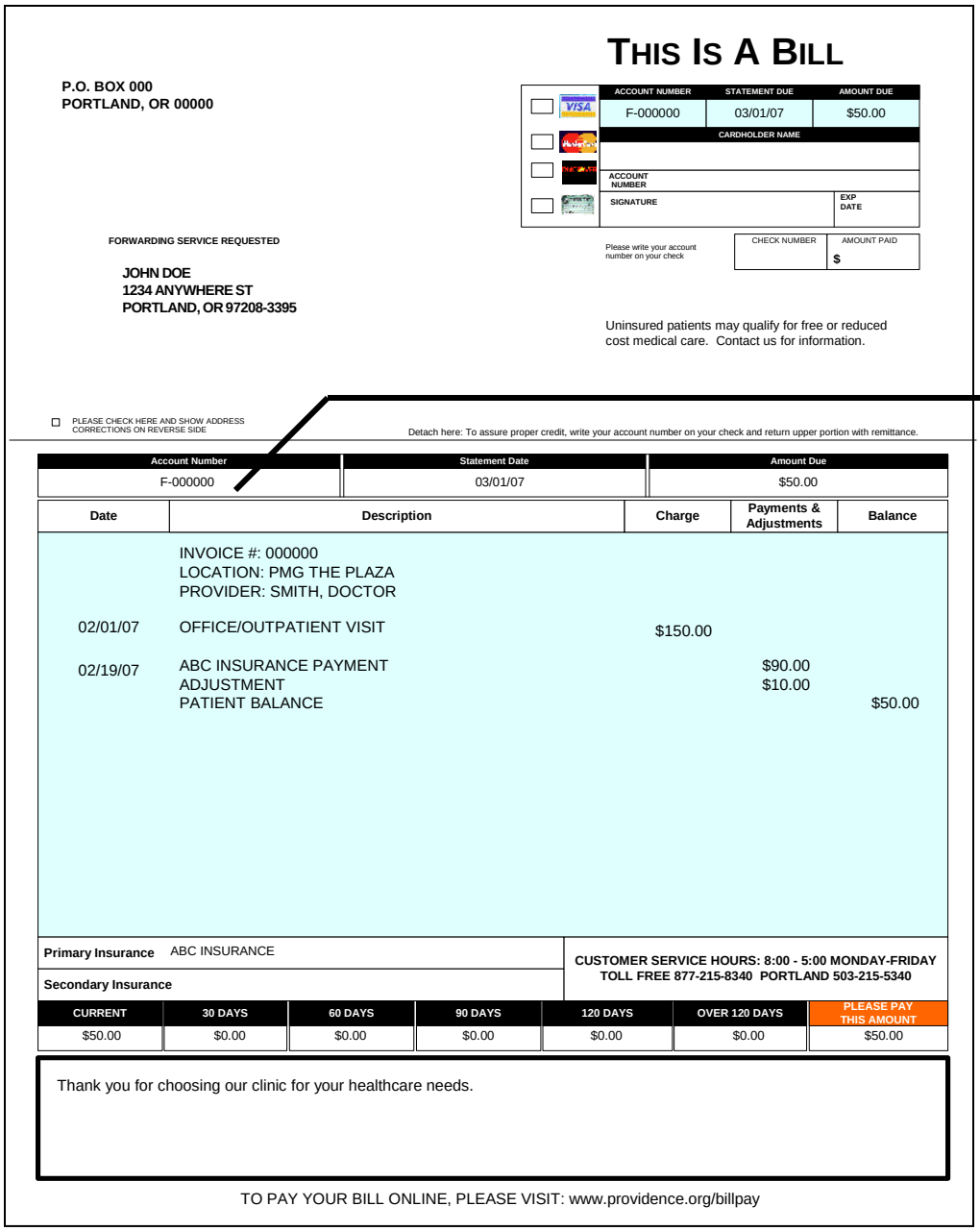
Sample Monthly Statement for services provided by Providence Medical Group clinics



THIS IS A BILL

P.O. BOX 000
PORTLAND, OR 00000

ACCOUNT NUMBER	STATEMENT DUE	AMOUNT DUE
F-000000	03/01/07	$50.00

CARDHOLDER NAME

ACCOUNT NUMBER

SIGNATURE | EXP DATE

Please write your account number on your check

CHECK NUMBER | AMOUNT PAID $

FORWARDING SERVICE REQUESTED

JOHN DOE
1234 ANYWHERE ST
PORTLAND, OR 97208-3395

Uninsured patients may qualify for free or reduced cost medical care. Contact us for information.

☐ PLEASE CHECK HERE AND SHOW ADDRESS CORRECTIONS ON REVERSE SIDE

Detach here: To assure proper credit, write your account number on your check and return upper portion with remittance.

Account Number	Statement Date	Amount Due
F-000000	03/01/07	$50.00

Date	Description	Charge	Payments & Adjustments	Balance
	INVOICE #: 000000 LOCATION: PMG THE PLAZA PROVIDER: SMITH, DOCTOR			
02/01/07	OFFICE/OUTPATIENT VISIT	$150.00		
02/19/07	ABC INSURANCE PAYMENT ADJUSTMENT PATIENT BALANCE		$90.00 $10.00	$50.00

Primary Insurance ABC INSURANCE

Secondary Insurance

CUSTOMER SERVICE HOURS: 8:00 - 5:00 MONDAY-FRIDAY
TOLL FREE 877-215-8340 PORTLAND 503-215-5340

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS	OVER 120 DAYS	PLEASE PAY THIS AMOUNT
$50.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00

Thank you for choosing our clinic for your healthcare needs.

TO PAY YOUR BILL ONLINE, PLEASE VISIT: www.providence.org/billpay

Your account number

This shaded area will include: a description of your healthcare services and any payments made on this account.

Customer Service phone number

Amount Due