

Full Reports, Patient Notice (Hospital Charges) Letter




Description [] [] [X]

Patient Notice (Hospital Charges) Letter

This report will print a letter for uninsured patients with recent hospital charges. It can be used to request updated insurance information, as well as offer a discount for early payment or set up monthly payment plans.

Close

Input Parameters

Doctor	<input type="text" value="Donnell MD, Craig"/>		
Facility	<input type="text"/>		
Company	<input type="text"/>		
From Date	<input type="text" value="7/22/2003"/>	To Date	<input type="text" value="7/31/2003"/>
<div style="border: 1px solid black; padding: 5px;"><p>Database Code: 5628-6160 Product Number: R12048 Centricity Version: 070 ReportRun Version: 60.1800 No valid license for report You must enter a valid license code</p></div>			
License Code	<input type="text"/>		

Medical Clinics,PC
3790 W. First St
Richardson, TX 75248

HOSPITAL PATIENT NOTICE

Date of Notice: February 25, 2005

Brenda G Marshall
7690 Monroe Blvd
Fort Mage, NE 43323

RE: Patient Name: Marshall, Eric
Treatment Date: 07/22/2003
Ticket Number: 000101
Treating Doctor: Truman
Balance Due: \$640.00

Our records indicate that you do not have insurance to cover your recent hospital stay. Enclosed you will find a statement of your account with us. As of today, your balance for this hospital visit is \$640.00. Additional charges may be pending.

If you do have insurance, we will be happy to file a claim for you if you provide us the necessary information. If this is the case, please forward your insurance information to us at the above address or contact our billing department at (214) 662-2000.

IF YOU DO NOT HAVE INSURANCE COVERAGE, CIRCLE WHICH OPTION YOU ARE SELECTING AND RETURN A COPY OF THIS LETTER WITH YOUR PAYMENT OR OPTION SELECTION

OPTION A: If payment is received in full by 03/27/2005 a 10% discount will apply and \$576.00 is the total discounted amount due. After 03/27/2005 the full balance of \$640.00 is due.

OPTION B: Remit full payment by credit card (Master Card/Visa/Discover).

I authorize the practice to charge the full Balance Due of \$640.00 to my credit card indicated below. .

OPTION C: Remit monthly payments by credit card (Master Card/Visa/Discover).

I authorize the practice to charge a monthly payment equal to \$75.00 on the 1st or 15th until the Balance Due is paid in full.

Name as it appears on credit card: _____

Credit Card Type (circle one): Master Card Visa Discover

Credit Card # _____ Exp. Date _____

V-code (Visa only) _____.

Authorized Signature: _____

Receipt will be mailed upon completion of processing.

OPTION D: Remit monthly payments of \$75.00 due on the 25th of this month and due each month no later than the 25th of the month until the Balance Due is paid in full.

IF YOU HAVE ANY QUESTIONS OR IF WE MAY ASSIST YOU FURTHER, PLEASE CONTACT ONE OF OUR BILLING REPRESENTATIVES AT (214) 662-2000.