





| DATE | PROC CODE | DESCRIPTION | CHARGES | CREDITS | INSURANCE BALANCE | PATIENT BALANCE |
|--|-----------------|-------------------|-----------------|------------|-------------------|-----------------|
| <p>SAVE A STAMP or receive an e-statement to pay on-line! Go to www.csdocs.com Questions regarding your statement? Email us at CSG.BILLING@CHKD.ORG</p> | | | | | | |
| ACCOUNT # | ACCOUNT BALANCE | PENDING INSURANCE | PATIENT BALANCE | TOTAL DUE: | | |
| | | | | | | |
| ACCOUNT NAME | | | | | | |
| <p>If we do not have your insurance information on file, please call us at 757-668-7200</p> | | | | | | |
| Important Message Regarding Your Account | | | | | | |

MAKE CHECKS PAYABLE TO:



ADDRESSEE:

Save time. Pay online!    

Pay your bill online at www.csdocs.com

Enter your online bill pay code:

See reverse side to make a payment by credit card or check.

| | |
|-------------------------|-------------------------------|
| PAYMENT DUE DATE | PATIENT RESPONSIBILITY |
| | |
| ACCOUNT NUMBER | STATEMENT DATE |
| | |

REMIT TO:

How Much Do I Really Owe?

You are responsible for the amount listed in the box PATIENT BALANCE. As every insurance plan is different, if you disagree with how your insurance paid on your account, please contact them prior to contacting our office.

What if I cannot pay in full?

Please call the practice's patient account representative at (757) 668-7200 weekdays 8:00 a.m. until 4:00 p.m. Monday - Friday.

Co-Pay:

A dollar amount contracted between you and your insurance carrier, due at time of service.

Co-Insurance:

A percentage of the insurance benefits that you are responsible for.











Deductible:

A yearly dollar amount that you are responsible for based on the type of coverage you have selected with your insurance company.

Adjustment:

A contractual agreement that has been made between our Doctor and your insurance company.

FOR QUESTIONS OR CONCERNS REGARDING YOUR DEDUCTIBLE, COPAY, CO-INSURANCE OR NON COVERED INSURANCE, PLEASE CALL YOUR INSURANCE COMPANY WHICH IS LOCATED ON YOUR INSURANCE CARD.

| PLEASE UPDATE ANY INFORMATION THAT HAS CHANGED SINCE YOUR LAST STATEMENT | |
|--|--|
| IF PAYING BY CREDIT CARD, FILL OUT BELOW | |
| VISA  | DISCOVER  |
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