



PO BOX 600 OAKS, PA 19456

Amount Due:

\$XXX.XX

Hi Patient! This is your CURRENT Billing Statement.

Thank you for entrusting your care to a Cincinnati GI doctor. Pay online now at www.PayMyDoctor.com. FREE, secure, easy. *NOTE* Use Practice ID 2275158



Account Name
CGI PATIENT

Account Number XXXXXXXX
Statement Date XX/XX/20XX

Total Balance \$XXX.XX
Due Date XX/XX/20XX

Self Service Payment Plan

Scan the below QR code to make a payment

Interest-Free Payment Plans



www.PayMyDoctor.com.

Make Payment in Full

Pay online using the website below and enter the Practice ID: 2275158

www.PayMyDoctor.com.



detailed summary on next page >



PO BOX 600 OAKS, PA 19456
PERSONAL & CONFIDENTIAL

Account Number XXXXXXXX
Please Pay This Amount \$XXX.XX

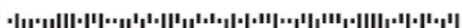
Address Service Requested

Amount Enclosed



75158.co1 1112 2275158
Stmt Date: XX/XX/20XX

ADDRESSEE:



CGI PATIENT
PO BOX 600
OAKS, PA 19456

MAKE CHECKS PAYABLE AND REMIT TO:



CINCINNATI GI
PO BOX 632958
CINCINNATI OH 45263-2958

Check if address/insurance changes are on back

| Date | Explanation of Activity | Charges | Payments/ Adjustments | Insurance Balance | Patient Balance |
|--------------------------|--|----------|--------------------------|----------------------|-----------------|
| xx/xx/20xx xx/xx/20xx | CGI Patient <i>Provider Name Voucher: XXXXXXX</i> Scope of the Colon Insurance Adjustment This amount represents your deductible. Please remit payment. Visit Total | \$XXX.XX | -\$XXX.XX | | \$XXX.XX |

Change of Address

Name (Last, First, Middle Initial) _____

Address _____

City _____ State _____ ZIP _____

Telephone _____

If Paying By Credit Card, Fill Out Below

CHECK CARD USING FOR PAYMENT    

CARD NUMBER _____ EXP. DATE

| | | | |
|---|---|---|---|
| M | M | Y | Y |
|---|---|---|---|

SIGNATURE _____ CVV CODE _____ AMOUNT PAID _____

Account Number: XXXXXXX

Primary Insurance Updates

Primary Insured Name _____

Primary Insurance Name _____ Effective Date _____

Primary Insurance Street Address _____

City _____ State _____ ZIP _____ Telephone _____

Employer Name _____ Group Number _____

Subscriber ID # _____ Policyholder's Date of Birth _____