

STATEMENT



WE ACCEPT MATERCARD, VISA, AND DISCOVER.
SEE REVERSE SIDE OF STATEMENT.

1 STATEMENT NUMBER: 36886631
2 P/C 11 **3** TEL. 319-234-7984
4 TOLL FREE 1-877-643-9413 **5** 07/24/2004 **6** 007-686-9 **7** 001 **8** \$ 62.30
 319-272-1599 CLOSING DATE ACCOUNT NO. PAGE NO. NEW BALANCE
 OFFICE PHONE NUMBER

9 JOHN Q. PUBLIC
 9212 MAIN ST
 WATERLOO, IA 50702

10 COVENANT CLINIC
 2101 KIMBALL AVE
 P.O. BOX 6200
 WATERLOO, IA 50704-6200

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE OF SERVICE	PROVIDER	DESCRIPTION	ACTIVITY DATE	CHARGES	INSURANCE ACTIVITY	PATIENT ACTIVITY	PATIENT RESPONSIBLE
		11 Previous Patient Balance	061904	51.19			
		CHARITY	062504			51.19-	
		12 PATIENT RESPONSIBLE					0.00
		JOHN PUBLIC 17-23-46					
050504	WAIT GERAL	INITIAL HOSPITAL CARE		231.00			
		DISALLOW MEDICARE	062504		124.68-		
		13 PAYMENT MEDICARE	062504		85.06-		
		PATIENT RESPONSIBLE					21.26
050504	WAIT GERAL	INSERTION OF CHEST TUBE		636.00			
		DISSALLOW MEDICARE	062504		430.82-		
		PAYMENT MEDICARE	062504		164.14-		
		PATIENT RESPONSIBLE					41.04

FOR CREDIT CARD PAYMENTS PLEASE SEE REVERSE SIDE OF THIS STATEMENT.
 THANK YOU FOR CHOOSING COVENANT CLINIC AS YOUR HEALTHCARE PROVIDER.

5 Statement WHEN CALLING OUR OFFICE, PLEASE INDICATE YOUR ACCOUNT NUMBER: **6** 007-686-9
 Closing Date: 07/24/2004 OR STATEMENT NUMBER: **2** 36886631

14 BALANCE 30 DAYS AND UNDER	BALANCE OVER 30 DAYS	BALANCE OVER 60 DAYS	BALANCE OVER 90 DAYS	PATIENT RESPONSIBLE NEW BALANCE
62.30				62.30

<p>16 CREDIT CARD PAYMENT</p> <p>You may pay this bill by credit card. Complete the form below and return in the enclosed envelope.</p> <p>AMOUNT: \$ _____</p> <p>CREDIT CARD: _____</p> <p>CARD NUMBER: _____</p> <p>CARD EXPIRES: <u> </u> / <u> </u> MO. YR.</p> <p>PRINT CARD HOLDER'S NAME: _____</p> <p>SIGNATURE: _____</p>	RESPONSIBLE PARTY / ADDRESS CORRECTION	
	NAME 17	TEL. NO. () -
	STREET ADDRESS	
	CITY/STATE	ZIP
	INSURANCE INFORMATION, IF REQUESTED	
INSURED'S NAME	PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	
INSURED'S ADDRESS 18		
INSURED'S DATE OF BIRTH	INSURED'S ID NO.	
SOCIAL SECURITY NO.	GROUP ID NO.	
EMPLOYER NAME	TEL. NO. () -	
EMPLOYER'S ADDRESS		
CITY/STATE	ZIP	
INSURANCE CO. NAME	TEL. NO. () -	
CITY/STATE	ZIP	

Thank you for entrusting Covenant Health System with your care. Your questions are important to us. We have included the following questions as a guide to help answer some of them.

How can I pay my portion of the bill?

Covenant Health System offers the following payment options:

- 19** ♦ Cash, check or money order. Please make check or money order payable to Covenant Clinic, and include your guarantor number on your check. Mail to: **Covenant Clinic, 2101 Kimball Avenue, P.O. Box 6200, Waterloo, IA 50704-6200**

*If paying cash please go to the facility where you received the services.

- ♦ Credit card. We accept MasterCard, VISA or Discover cards.

20 When do I become responsible for my bill?

You are legally responsible for your bill at the time you receive services from the clinic. We ask that all patient balances be paid once you have been notified of the balance.

21 Who can I talk to with questions about my bill?

Billing representatives are available to help you with any questions or concerns you may have about your bill. Representatives are available Monday through Friday, 8 a.m. to 5 p.m., and can be contacted at (319) 272-1599 or (877) 643-9413.

22 How can I get a copy of my bill?

Please contact the Billing Office at (319) 272-1599 or (877) 643-9413 to request that a copy of your itemized bill be sent to you. If you are leaving a message please include the guarantor number from your statement.

23 Medicare Patients: Covenant Medical Center and its affiliated physician network, Covenant Clinic, have been designated by Medicare as "Hospital-Based" organizations. This designation affects the way Medicare accounts are billed. As a Medicare patient being seen by a Covenant Clinic physician, you will be billed under Hospital-Based status and services rendered will be billed in two parts - a professional fee billed by Covenant Clinic and a facility fee billed by Covenant Medical Center. Questions can be directed to our Hospital-Based Billing department. If your last name begins with: A-G, (319) 272-1933; H-O, (319) 272-1932; or P-Z (319) 272-1931.

Understanding Your Billing Statement

1. **Facility Name** – The facility name and address appears here.
2. **Statement Number** – The number that identifies what statement was sent to the guarantor
3. **Telephone Number** – Identifies the guarantor's telephone number.
4. **Office Phone Number** – Telephone number you can use to call the clinic business office.
5. **Closing Date** – The date the statement was generated.
6. **Account Number** – Account number being sent a statement.
7. **Page Number** – Page number of the statement if there is more than one page.
8. **New Balance** – Total of all the guarantor responsible balances associated with this statement.
9. **Guarantor Name and Mailing Address** – The name and address of the guarantor associated with the statement.
10. **Office Name and Mailing Address** – Identifies the name and address to which the guarantor mails their payment.
11. **Previous Patient Balance** – Identifies the guarantor responsible balance and account activity since the last statement date.
12. **Patient Responsible** – Identifies the patient who received the service in the clinic.
13. **Patient Activity** – Identifies the patient's activity to include:
 - Date of service
 - Name of provider
 - Description of activity
 - Activity date
 - Charges
 - Insurance activity
 - Patient activity
 - Patient responsible balance
14. **Aging Groups** – the total balance is separated into 30 day aging groups.
15. **Covenant Clinic locations** – a list of all Covenant Clinic locations.
16. **Credit Card Payment** – If paying by credit card, use this area to complete the necessary information.
17. **Responsible Party Address Correction** – Enter any updated or corrected information.
18. **Insurance Information if Requested** – Enter updated or corrected information.
19. **How I can pay my portion of the bill** – Where payments can be sent to.
20. **When do I become responsible for any bill** – Defines when you are legally responsible to pay your bill.
21. **Who can I talk to with questions** – General billing question contact information.
22. **How do I get a copy of my bill** – Information about how to receive a copy of your bill.
23. **Medicare Patients** – General information about how Medicare patients claims are processed.