

Front



**Lifespan**

164 SUMMIT AVENUE  
PROVIDENCE, RI  
02906

For Account Information, Please Call 401-444-6966

**Patient Name**

Service Date: 07/28

Service End:

Last Statement Date:

Account No: 111111111

**Statement of Account 08/15/05**

| Transaction Date         | Description      | Amount                  |
|--------------------------|------------------|-------------------------|
|                          | PREVIOUS BALANCE | 672.00                  |
|                          |                  |                         |
| Estimated Insurance Due: | 562.80           | Total Patient Credits:  |
|                          |                  | Account Balance: 672.00 |

OFFICE HOURS ARE MONDAY THRU FRIDAY, 9:00AM TO 4:30PM  
PATIENT BALANCE DUE AND PAYABLE UPON RECEIPT. IF YOU  
HAVE QUESTIONS ON YOUR BILL-CALL (401)444-6966,M-F,9AM-4PM.

THE MIRIAM HOSPITAL

Please detach and return with your payment

THE MIRIAM HOSPITAL  
164 SUMMIT AVENUE  
PROVIDENCE, RI  
02906

ADDRESS SERVICE REQUESTED

|                       |  |                                                                                                     |  |                                                   |  |
|-----------------------|--|-----------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|
| For Hospital Use Only |  | Account Number:                                                                                     |  | Please Pay This Amount:                           |  |
| ADM DT: 072805        |  | 1111111111                                                                                          |  | 109.20                                            |  |
| DSH DT: "NONE"        |  | Patient Name:                                                                                       |  | Due By:                                           |  |
| FC: B                 |  | Patient Name                                                                                        |  | 08/29/05                                          |  |
| MR:                   |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  | <input type="checkbox"/> <input type="checkbox"/> |  |
| RC:                   |  | Card Number:                                                                                        |  | CVV2 No.*                                         |  |
| HR: TME               |  | Signature:                                                                                          |  | Exp. Date:                                        |  |
| DP: 081105            |  |                                                                                                     |  | Amount Paid:                                      |  |

Make Check Payable To THE MIRIAM HOSPITAL

\* The CVV2 Number is the last 3 digits on the back of your credit card, by your signature

00000075 1 SP 0.370 01

PATIENT NAME  
1212 MAIN ST  
ANYTOWN USA

THE MIRIAM HOSPITAL  
P.O. BOX 1202  
PROVIDENCE, R.I. 02901-1202

☐

Please check this box if your address or insurance information has changed and record the changes on the back of this statement

Back

 **The Miriam Hospital**  
164 SUMMIT AVENUE  
PROVIDENCE, RI 02906

For Account Information, Please Call 401-444-0966

Please use the number listed here to contact us about your account.

Patient Name: \_\_\_\_\_  
Service Date: 03/28  
Service End: \_\_\_\_\_  
Last Statement Date: \_\_\_\_\_  
Account No.: 111111111

Patient Name and Account Number - please refer to this account number when contacting us via telephone or mail about your account.

**Statement of Account 08/15/05**

| Transaction Date | Description      | Amount |
|------------------|------------------|--------|
|                  | PREVIOUS BALANCE | 472.90 |

This is the summary of your charges incurred for services provided during your treatment on the date indicated at a Lifespan facility. All payments/adjustments posted to this account are also displayed in this section of your statement. All physician charges are billed separately.

Estimated Insurance Den: 562.80      Total Patient Credits: \_\_\_\_\_      Account Balance: 672.00

OFFICE HOURS ARE MONDAY THRU FRIDAY, 8:00AM TO 4:00PM  
PATIENT BALANCE DUE AND PAYABLE UPON RECEIPT. IF YOU HAVE QUESTIONS ON YOUR BILL, CALL (401) 366-8088, M-F, 8AM-4PM.  
THE MIRIAM HOSPITAL

Use this section to make a payment on your account with one of these credit cards.

This is the patient balance due on your account.

Please attach and return with your payment.

For Hospital Use Only  
ADM DT: 07/20/05  
DSH DT: "NONE"  
FD: B  
MPL: \_\_\_\_\_  
RCL: TME  
HR: 08/11/05  
CP: 08/11/05

Account Number: 111111111  
Patient Name: \_\_\_\_\_  
Service Date: 08/29/05  
Service End: \_\_\_\_\_  
Last Statement Date: \_\_\_\_\_  
Account No.: 111111111

Make Check Payable To: THE MIRIAM HOSPITAL  
\* The CVV2 Number is the last 3 digits on the back of your credit card.

This is the date your payment is due.

00000075 1 SP 6.370 01  
PATIENT NAME  
1212 MAIN ST  
ANYTOWN USA

THE MIRIAM HOSPITAL  
P.O. BOX 1202  
PROVIDENCE, R.I. 02901-1202

Send your payment to the address listed on reverse side.

☐ Please check this box if your address or insurance information has changed and record the changes on the back of this statement.

Please use this space to make corrections to your address or insurance information.

Name: \_\_\_\_\_ Account No: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Policy or Contract No: \_\_\_\_\_ Group No: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Gender: ☐ M ☐ F Policy Holder's Social Security No: \_\_\_\_\_

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other \_\_\_\_\_