PO BOX 869
NORFOLK, NE 68702-0869

1609

0101

IF PAYING BY MASTERCARD, DISCOVER OR VISA, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
5/04/06		

PAGE: 1 of 1

SHOW AMOUNT PAID HERE $

ADDRESSEE:

REMIT TO:

FAITH REGIONAL HEALTH SERVICES
PO BOX 869
NORFOLK, NE 68702-0869

1609*1SM0DT5H3004329

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

310227A

DATE	PATIENT	ACCOUNT NUMBER	DESCRIPTION/FC	CHARGES	DISCHARGE
			BALANCE FORWARD		
			NEW ACCOUNT BALANCE		
			PATIENT RESPONSIBILITY		
			RESPONSIBILIDAD DEL PACIENTE		

ACCOUNT NUMBER

Payment options or payment-in-full must be made after receiving this statement.
If you need assistance, please call the number on the back of this statement.
Thank you.

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . . .

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY | STATE | ZIP

TELEPHONE ( ) | MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME | TELEPHONE ( )

EMPLOYER'S ADDRESS | CITY | STATE | ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME

PRIMARY INSURANCE COMPANY'S ADDRESS | PHONE

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME

SECONDARY INSURANCE COMPANY'S ADDRESS | PHONE

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

PAYMENT POLICY

The charges listed on the front side of this statement represent services received at Faith Regional Health Services. These charges may include Emergency Room physician charges if you were a patient in our Emergency Room. Faith Regional Health Services also bills for psychiatric services, surgical assist services and infectious disease services. Any other physician charges will be billed by your physician's office.

Please select one of the payment options below if you have an amount not covered by insurance.

1. **Payment-in-full Option With Discount:** If you pay your self-pay balance within 30 days of your first self-pay statement, you may take 5% off of your balance. Send in 95% of your self-pay balance due to take advantage of this discount. If you pay your self-pay balance in full within 60 days of your first self-pay statement, you may take a 2.5% discount. Just send us 97.5% of your self-pay balance. If you need help in determining the amount to send, please call the number below and our staff will be happy to assist you. Balances under $50.00 are required to be paid-in-full less your discount.
2. **30-60-90 Day Option:** Pay your account balance over a 90 day period and avoid finance charges. You may pay 1/3 of your outstanding balance each month. Your first payment is due within 30 days of your first self-pay statement. If you have any questions, please contact you Patient Financial Services Representative listed below.
3. **Monthly Payment Option:** If you need more than 90 days to pay your account balance, select this payment option. There will be an interest or finance charge, of one percent (1%) per month added to all charges that remain unpaid after ninety (90) days. This is an open-end credit agreement. You will be able to add future self-pay balances once you have established your account. Monthly payments are determined based upon your current balance.

If Your Balance Is Between:	Your Monthly Payment Is:
$ 0.00 - $750.00	$50.00
$ 751.00- $1,500.00	$100.00
$1,501.00-$2,500.00	$150.00
$2,501.00-$3,500.00	$200.00
For amounts greater than $3,500.00	Monthly payment increases by $50.00 for each additional $1,000.00

4. **Patient Financial Assistance:** Faith Regional Health Services offers a financial assistance program to those patients with no or limited financial resources. If you think that you might qualify, please call the number listed below.

It is important that you select one of the payment options or the financial assistance program listed above. If your account is not paid within 90 days or if you have not followed the payment policy guidelines, your account may be referred for further collection action.

For more information regarding billing and general information regarding Faith Regional Health Services, please visit our website at http://www.frhs.org.

For assistance with payment of your account or if you have questions regarding your insurance, please call **(402) 644-7145**. Please listen for the options that will guide your call to the person who can assist you.

Thank You!