



PATIENT BUSINESS SERVICES  
PO BOX 4020  
LA CROSSE, WI 54602-4020

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

1  MASTERCARD  VISA  DISCOVER

CARD NUMBER \_\_\_\_\_ AMOUNT \_\_\_\_\_

SIGNATURE \_\_\_\_\_ EXP. DATE \_\_\_\_\_

2 STATEMENT DATE 8/25/05 PAY THIS AMOUNT 01 3 ACCOUNT # 00-00000

SHOW AMOUNT PAID HERE \$

ADDRESSEE:

JOHN Q. PATIENT  
123 MAIN ST  
ANYTOWN, WI #####

REMIT TO:

GUNDERSEN CLINIC LTD  
PATIENT BUSINESS SERV NCA3-01  
PO BOX 4020  
LA CROSSE, WI 54602-4020

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side. Please detach and return top portion with your payment.

DATE OF SERVICE	PROVIDER	DESCRIPTION	POSTING DATE	CHARGES	INSURANCE ACTIVITY	PAYMENT ACTIVITY	PATIENT RESPONSIBLE
		Previous Patient Balance	071505	15.00			
		PERS. PAYMENT CHECK - THANK YOU	080505			15.00-	00.00
		<b>PATIENT RESPONSIBLE</b>					
		<b>JOHN Q PATIENT 000000-00-00-0</b>					
052705	T SMITH	LAB-STREP RAPID TEST		49.70			
		GUNDERSEN LUTHERAN HLTH PLAN PMT072805			42.30-		7.40
		<b>PATIENT RESPONSIBLE</b>					
052705	T SMITH	EVAL & MGMT, OFFICE ESTAB PT		89.70			
		GUNDERSEN LUTHERAN HLTH PLAN PMT081005			69.70-		20.00
		<b>PATIENT RESPONSIBLE</b>					
		<b>MARY Q PATIENT 000000-00-00-0</b>					
060605	M JONES	COMPREHENSIVE OPTOMETRY EXAM		111.50			
		GUNDERSEN LUTHERAN HLTH PLAN ADJ 081505			6.73-		0.00
		GUNDERSEN LUTHERAN HLTH PLAN PMT081505			94.77-		
		<b>PATIENT RESPONSIBLE</b>					
060605	M JONES	DETERMINATION-REFRACTIVE STATE		32.00			32.00
		<b>PATIENT RESPONSIBLE</b>					
		<b>PERSONAL PAYMENT SUMMARY</b>					
		PERS. PAYMENT CHECK - THANK YOU	080505			15.00-	
		TOTAL PAYMENTS NOT APPLIED				10.00-	
						<b>Payment Total</b>	
						15.00-	
						10.00-	
Statement Closing Date: 8/25/2005		WHEN CALLING OUR OFFICE, PLEASE INDICATE YOUR ACCOUNT NUMBER:				00-00000	
BALANCE 30 DAYS AND UNDER	BALANCE OVER 30 DAYS	BALANCE OVER 60 DAYS	BALANCE OVER 90 DAYS	PATIENT RESPONSIBLE			
59.40				NEW BALANCE			59.40

**SAMPLE DO NOT PAY**

Send inquiries to:  
GUNDERSEN CLINIC LTD  
PATIENT BUSINESS SERV  
PO BOX 4020  
LA CROSSE, WI 54602-4020

Your scheduled monthly payment is: \_\_\_\_\_

## How to read your clinic billing statement

- To pay by credit card, complete this section and sign your name.
- Last date of activity on this statement.
- This number identifies your account.
- This column shows how your insurance processed the charges.
- Balances in this column are your responsibility if:
  - Your insurance was processed and there is a balance due.
  - Your insurance processed the claim and paid you directly.
  - You do not have insurance coverage.
  - We have not heard from your insurance company.
- Co-pays and pre-payments for recent visits don't show as "Patient Activity" and will not be subtracted from the amount due until related charges appear on a future statement. This line confirms we received your payment.
- Your personal payment has been subtracted from the amount due in **8**.
- This is the amount you pay. It is due 21 days after the statement date in box **2** unless you have made payment arrangements with us.
- If you have a payment arrangement, the amount you pay each month shows here.

Call (608) 775-8660 or (800) 362-9567, ext. 58660 from 7:30 a.m. to 5:30 p.m. Monday through Friday when you have questions about your statement, need to make payment arrangements or need to correct the billing name or address on your statement.