Page 2 of Your Monthly Billing Statement

1. PATIENT: Name of the patient who received the services
2. ACCOUNT NUMBER: Identifies the account number for the services provided
3. VISIT TYPE: Service Area where services were provided
4. STATUS: The payment due status of the account
5. LOCATION: The University HealthCare Alliance Office location where services were provided
6. DATE: The date services were provided
7. DESCRIPTION: The description of the service, payment, or adjustment, applied to the account
8. CHARGES: The amount charged for the service
9. PAYMENT/ADJUSTMENT: The payments and adjustments applied to the account
10. INSURANCE BALANCE: The amount currently showing due from insurance on this account
11. PATIENT BALANCE: The amount currently showing due from the Guarantor on this account

Account Details

Date	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
1 Patient: John Doe			**2 Acct#: 87654321**		
3 Service Provider: SMITH, DAVID			**4 Status Due Upon Receipt**		
5 UHA Location: ABC Family Physicians Medical Group					
6	7	8	9	10	11
6/27/2016	EVAL/MGMT OF EST PATIENT	$157.00			
	UNINSURED DISCOUNT ADJ		$-78.50		
	Totals	**$157.00**	**$-78.50**	**$0.00**	**$78.50**
	Patient Balance			**$0.00**	**$78.50**
Patient: John Doe			**Acct#: 98765432**		
Service Provider: SMITH, DAVID			**Status Due Upon Receipt**		
6/27/2016	EVAL/MGMT OF EST PATIENT	$345.00			
	OBTAINING SCREEN PAP SMEAR	$125.00			
	UNINSURED DISCOUNT ADJ		$-172.50		
	UNINSURED DISCOUNT ADJ		$-62.50		
	Totals	**$470.00**	**$-235.00**	**$0.00**	**$235.00**
	Patient Balance			**$0.00**	**$235.00**
	Balance Due				**$313.50**

Stanford HEALTH CARE

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