Hospital Account Statement – page 1

Key to important information on your statement:

- (A) - Account Number
- (B) - Amount Due from You
- (C) - Date Payment is Due
- (D) - Date(s) of Service
- (E) - Payment and Credit Activity
- (F) - Insurance Information

Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER

You will receive separate statements from Lucile Packard Children's Hospital and Stanford Hospital & Clinics.

SAMPLE A. SAMPLE
123 MAIN ST
ANYTOWN, XX 12345-1234

This is the Hospital Account Statement

Important Message

Thank you for selecting Stanford Hospital & Clinics.

This bill is a summarized statement of your hospital account at Stanford Hospital. A complete itemized statement for each account is available upon request.

Please note your physicians will bill separately for their professional services.

Hospital Account Summary

Statement Date	06/18/2004
Service Date(s) (D)	04/17/1997
(A) Account Number	999999999999
Total Charges	$ 2,570.26
Patient Payments	$ 0.00
Insurance Payments (E)	$ 0.00
Insurance Adjustments	$ 0.00
Other Adjustments*	$ 0.00
(C) Balance Due Upon Receipt (B)	$ 2,570.26

Insurance Information

Please confirm that the information is correct for: (F)

Patient Name	SAMPLE A. SAMPLE
Medical Record No.	99999999
Guarantor Name	SAMPLE A. SAMPLE
Primary Insurance	INSURECO
Secondary Insurance	NIGHT FLYER

Questions

- **Questions?**
  Call **(650) 498-7200 or (800) 333-7491** to reach Customer Service during our regular business hours (Monday - Friday, 8:00 am to 5:00 pm) or our new Automated Voice Telephone System 24 hours a day, 7 days a week.
- **Billing Office Location:**
  2690 Hanover Street in Palo Alto, CA.
  Hours are Monday-Friday from 9:00 am to 4:00 pm.
- **Mail Payments To:**
  Stanford Hospital & Clinics
  File 74431 PO Box 60000
  San Francisco, CA 94160
- **Make Checks or Money Orders Payable to:**
  Stanford Hospitals & Clinics

Statement Date: 06/18/2004

999999999999 $ 2,570.26

REMIT THIS PAYMENT STUB TO:

STANFORD HOSPITAL & CLINICS
FILE 74431 PO BOX 60000
SAN FRANCISCO, CA 94160

Patient Name	Medical Record	Date Due
SAMPLE A. SAMPLE	99999999	Upon Receipt

Amount Due	Amount I Am Paying
$ 2,570.26	$

☐ *Check here if your address or insurance information has changed. Please indicate changes on the back of this page.*

To pay by credit card: For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.

Account No. ____________________

Expiration Date ____________________

Signature X ____________________

I authorize Stanford Hospital & Clinics to charge my credit card for the amount indicated.

SUMCD1S1-01

Hospital Account Statement – page 2

You will receive a statement for each hospital account if and when the balance becomes your responsibility.

Patient Services Provided - Itemized Charges

Summarized Detail of Stanford Hospital Account Number 999999999999

A summarized detail of services and charges for each outstanding account due is provided below. A complete itemized statement for each account is available upon request. Please keep this page for further reference.

Account Number: 999999999999 (A) **Service Date(s): 04/17/1997** (D) **Type of Service: Outpatient**

Payment is due upon receipt. Please enter the amount you are paying on the remittance stub, detach, and send with your check, money order, or credit card information in the enclosed reply envelope.

Services and Charges	
LABORATORY	$ 2,570.26
Total Charges	**$ 2,570.26**

Payments and Adjustments as of 06/18/2004	
Patient Payments	$ 0.00
Insurance Payments	$ 0.00
Insurance Adjustments	$ 0.00
Other Adjustments*	$ 0.00
Amount You Owe for this Account	**$ 2,570.26**

(E) (B)

*See Reverse of Page One for Additional Information