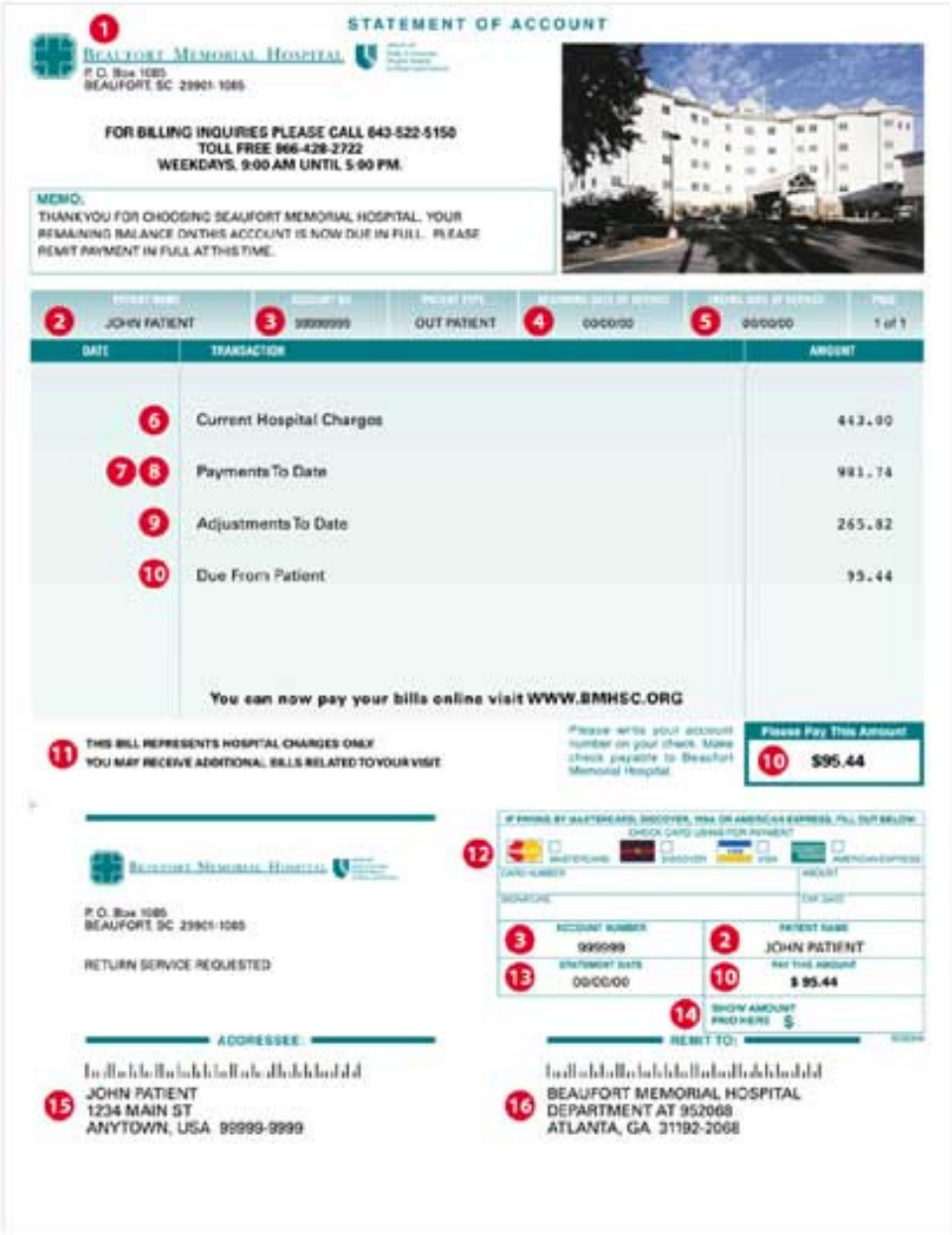

STATEMENT OF ACCOUNT

1 BEAUFORT MEMORIAL HOSPITAL
P.O. Box 1085
BEAUFORT, SC 29901-1085

FOR BILLING INQUIRIES PLEASE CALL 843-522-5150
TOLL FREE 866-428-2722
WEEKDAYS, 9:00 AM UNTIL 5:00 PM.

MEMO:
THANK YOU FOR CHOOSING BEAUFORT MEMORIAL HOSPITAL. YOUR REMAINING BALANCE ON THIS ACCOUNT IS NOW DUE IN FULL. PLEASE REMIT PAYMENT IN FULL AT THIS TIME.

2 PATIENT NAME	3 ACCOUNT NO	PATIENT TYPE	4 BEGINNING DATE OF SERVICE	5 ENDING DATE OF SERVICE	PAGE
JOHN PATIENT	99999999	OUT PATIENT	00/00/00	00/00/00	1 of 1

DATE	TRANSACTION	AMOUNT
	6 Current Hospital Charges	443.00
	7 8 Payments To Date	981.74
	9 Adjustments To Date	265.82
	10 Due From Patient	95.44

You can now pay your bills online visit WWW.BMHSC.ORG

11 THIS BILL REPRESENTS HOSPITAL CHARGES ONLY
YOU MAY RECEIVE ADDITIONAL BILLS RELATED TO YOUR VISIT

Please write your account number on your check. Make check payable to Beaufort Memorial Hospital.

Please Pay This Amount
10 $95.44

BEAUFORT MEMORIAL HOSPITAL
P.O. Box 1085
BEAUFORT, SC 29901-1085

RETURN SERVICE REQUESTED

ADDRESSEE

15 JOHN PATIENT
1234 MAIN ST
ANYTOWN, USA 99999-9999

12 IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT
MASTERCARD DISCOVER VISA AMERICAN EXPRESS
CARD NUMBER
AMOUNT
SIGNATURE
DAY DATE

3 ACCOUNT NUMBER	2 PATIENT NAME
999999	JOHN PATIENT
13 STATEMENT DATE	10 PAY THIS AMOUNT
00/00/00	$ 95.44

14 SHOW AMOUNT PAID HERE $

REMIT TO:

16 BEAUFORT MEMORIAL HOSPITAL
DEPARTMENT AT 952068
ATLANTA, GA 31192-2068

KEY TO BILL

1. Name of Hospital

2. Name of Patient

3. First 9 digits are the patient's meical record number; last 4 digits are the visit for which the patient is being billed.

4. Date of Service

5. Date of Release

6. Total Billed for this Visit

7/8. Total amount received from the Patient and the Insurance Company.

9. Preferred Insurance Discount for which you qualify

10. Amount due from You

11. Important informaiton to read about your account.

12. Credit Cards accepted by the Hospital.

13. Date this statement was mailed.

14. Amount you are paying.

15. Patient name and address.

16. Hospital name and address.