

Pay Online/Pay as Guest  
[mychart.parkview.com](http://mychart.parkview.com)  
 Click Pay as Guest

**PAYMENT DUE**
**\$000.00**

# Your Account Status

We have billed your insurance and the remaining balance is your responsibility. One or more of your accounts are now past due.

GUARANTOR NAME	GUARANTOR #	STATEMENT DATE	PAYMENT DUE DATE
Joan Sample	00000000	00/00/20	00/00/20

## YOUR NEXT STEP

To resolve your past due account, make payment in full or call to set up a payment plan.



### PAY YOUR BILL ONLINE OR BY PHONE TODAY!

Go to [mychart.parkview.com](http://mychart.parkview.com) or call (260) 266-6700 or toll free (855) 814-0012.



### SET-UP A PAYMENT PLAN

Please call (260) 266-6700 or toll free (855) 814-0012 to arrange a payment plan agreement to fulfill your outstanding balance. You can also set up payment plans through your MyChart account.



### FINANCIAL ASSISTANCE

Parkview Health offers financial assistance to patients whose family income meets eligibility requirements. For more information regarding assistance or to obtain a copy of the Financial Assistance Policy or Financial Assistance Application visit [mychart.parkview.com](http://mychart.parkview.com) or call (260) 266-6700 or toll free (855) 814-0012.

## General Questions

If you have questions about your bill, please call (260) 266-6700 or toll free (855) 814-0012 Mon - Fri 8:00am - 5:15pm



**PAY ONLINE 24/7**  
[mychart.parkview.com](http://mychart.parkview.com)

Detach this coupon and return with your payment.

IF PAYING BY CREDIT/DEBIT CARD		
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER		EXP DATE
SIGNATURE		
STATEMENT DATE	GUARANTOR #	DUE DATE
00/00/20	00000000	00/00/20
AMOUNT DUE	SHOW AMOUNT PAID HERE	
<b>\$000.00</b>		

PLEASE MAKE CHECKS PAYABLE TO PARKVIEW HEALTH


 JOAN SAMPLE  
 123 MAIN STREET  
 ANYTOWN, IN 12345-1234

 PARKVIEW HEALTH  
 PO BOX 10416  
 DES MOINES, IA 50306

**Financial Assistance Policy - Plain Language Summary**

The Plain Language Summary is being provided to you to help explain Parkview Health's Financial Assistance Policy. It summarizes eligibility requirements for assistance and provides contact information so that you can obtain further information regarding the Policy or applying for financial assistance.

**Do I qualify?**

Patients whose family income does not exceed twice the Federal Poverty Guidelines may be eligible for financial assistance. Certain family assets are considered in making the determination for eligibility under the Financial Assistance Policy. Patients must complete a Financial Assistance Application in order to be considered under Parkview's Financial Assistance program. Patients must apply for Financial Assistance within 240 days of the date a patient is sent the first statement due for that date of service. Patients eligible for financial assistance will not be charged more than the Amount Generally Billed. The Amount Generally Billed is defined as the amount by Medicare for emergent or medically necessary care.

**How do I obtain more information?**

The Financial Assistance Policy and the Financial Assistance Application provide more detailed information regarding eligibility and the application process, and are available on Parkview.com or by sending a written request to:

Attention: ARS Team Patient Financial Services  
Parkview Health  
P.O. Box 5600  
Fort Wayne, IN 46895

The Financial Assistance Policy and the Financial Assistance Application are also available by calling the Patient Financial Services Call Center at 260-266-6700 or toll free 855-814-0012, or by visiting any cashier office between the hours of 9:00 am and 4:00 pm at the following locations:

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**Parkview Hospital Randallia**  
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Fort Wayne, IN 46805

**Parkview Huntington Hospital**  
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Huntington, IN 46750

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401 Sawyer Road  
Kendallville, IN 46755

**Parkview Wabash Hospital**  
710 N. East Street  
Wabash, IN 46992

**Parkview Warsaw**  
1355 Mariners Drive  
Warsaw, IN 46582

**Parkview Whitley Hospital**  
1260 E. State Road 205  
Columbia City, IN 46725

# STATEMENT OF SERVICES

GUARANTOR #: 00000000

PATIENT NAME	PLACE OF SERVICE	TYPE OF SERVICE	VISIT DATE	SERVICES DESCRIPTION	CHARGES	PAYMENTS & ADJ.	BALANCE
Physicians Jamie Sample	Parkview Regional Medical Center & Affil	Outpatient	0/0/20	Account # <b>500001234567891</b>	\$00,000.00	\$-00,000.00	\$0,000.00
			0/0/20	CONTRACTUAL WRITE-OFF - Medicare		-\$0,000.00	
<b>PAST DUE</b>							<b>\$0,000.00</b>

### QUESTIONS?


 Go to [www.parkview.com](http://www.parkview.com) to look up medical records, make payments, and more!


For questions call the Billing Office at: (260) 266-6700 or toll free (855) 814-0012/Mon - Fri 8:00am - 5:15pm

<b>HOSPITAL AMOUNT DUE</b>	<b>\$0,000.00</b>
<b>PHYSICIAN AMOUNT DUE</b>	<b>\$0,000.00</b>
<b>HOME HEALTH AMOUNT DUE</b>	<b>\$0,000.00</b>
<b>PAYMENT PLAN AMOUNT</b>	<b>\$0,000.00</b>
<b>AMOUNT DUE NOW</b>	<b>\$0,000.00</b>



AMOUNT DUE WITH  
 PROMPT PAY DISCOUNT  
 IF PAID BY \_\_\_\_\_  
 \$ \_\_\_\_\_

AMOUNT DUE WITHOUT PROMPT  
 PAY DISCOUNT IF PAID AFTER  
 \_\_\_\_\_  
 \$ \_\_\_\_\_

## Your Account Status >

We have billed your insurance and the remaining balance is your responsibility. One or more of your accounts are now past due.

GUARANTOR NAME	GUARANTOR #	STATEMENT DATE	PAYMENT DUE DATE
Joan Sample	00000000	00/00/20	00/00/20

### YOUR NEXT STEP >

Take advantage of the prompt pay discount by making payment in full before the prompt pay due date or call to set up a payment plan or discuss financial assistance.



#### PAY YOUR BILL ONLINE OR BY PHONE TODAY!

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**Don't miss your chance at a prompt pay discount**

*please turn over for important information >*

Detach this coupon and return with your payment.

IF PAYING BY CREDIT/DEBIT CARD			
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	
CARD NUMBER			EXP DATE
SIGNATURE			
STATEMENT DATE	ACCOUNT #	DUE DATE	IF PAID BY 00/00/17
00/00/20	00000000	00/00/20	<b>\$000.00</b>
AMOUNT DUE		SHOW AMOUNT PAID HERE	
<b>\$000.00</b>			

PLEASE MAKE CHECKS PAYABLE TO PARKVIEW HEALTH



JOAN SAMPLE  
 123 MAIN STREET  
 ANYTOWN, IN 12345-1234

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 PO BOX 10416  
 DES MOINES, IA 50306

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**Parkview Whitley Hospital**  
1260 E. State Road 205  
Columbia City, IN 46725

# STATEMENT OF SERVICES

GUARANTOR #: 00000000

PATIENT NAME	PLACE OF SERVICE	TYPE OF SERVICE	VISIT DATE	SERVICES DESCRIPTION	CHARGES	PAYMENTS & ADJ.	BALANCE
Jamie Sample	Parkview Regional Medical Center & Affil	Outpatient	0/0/20	Account # <b>500001234567891</b>	\$00,000.00	\$-00,000.00	\$0,000.00
<b>Hospital</b>			0/0/20	IV THERAPY - GENERAL CLASSIFICATI	173.00		
			0/0/20	LABORATORY - CHEMISTRY	108.00		
			0/0/20	LABORATORY - HEMATOLOGY	88.00		
			0/0/20	LABORATORY - BACTERIOLOGY AND	99.00		
			0/0/20	LABORATORY - UROLOGY	117.00		
			0/0/20	RADIOLOGY - DIAGNOSTIC - CHEST X-	698.00		
			0/0/20	EMERGENCY ROOM - GENERAL CLAS	821.00		
			0/0/20	PHARMACY - EXTENSION OF 025X - D	54.09		
			0/0/20	MEDICALLY UNINSURED DISCOUNT			-647.43
			0/0/20	<b>PROMPT PAY DISCOUNT</b>			<b>-151.07</b>
				<b>CURRENT BALANCE</b>			

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<b>HOSPITAL AMOUNT DUE</b>	<b>\$0,000.00</b>
<b>PHYSICIAN AMOUNT DUE</b>	<b>\$0,000.00</b>
<b>HOME HEALTH AMOUNT DUE</b>	<b>\$0,000.00</b>
<b>PAYMENT PLAN AMOUNT</b>	<b>\$0,000.00</b>
<b>AMOUNT DUE NOW</b>	<b>\$0,000.00</b>

**Your Account Status >**

One or more of your accounts is now in Final Notice stage. To avoid collection activity, please see your next step below.

GUARANTOR NAME	GUARANTOR #	STATEMENT DATE	PAYMENT DUE DATE
Joan Sample	00000000	00/00/20	00/00/20

**YOUR NEXT STEP >**

Pay in full or contact us immediately to avoid further collection efforts.



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CARD NUMBER		EXP DATE
SIGNATURE		
STATEMENT DATE	GUARANTOR #	DUE DATE
00/00/20	00000000	00/00/20
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<b>\$000.00</b>		

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**PAYMENT DUE**
**\$000.00**

# STATEMENT OF SERVICES


GUARANTOR #: 00000000


**[ FINAL ]**  
**[ NOTICE ]**  
 YOUR ACCOUNT MAY BE PLACED WITH A COLLECTION AGENCY AND REPORTED ON YOUR CREDIT REPORT IF WE DO NOT RECEIVE PAYMENT IMMEDIATELY.

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PATIENT NAME	PLACE OF SERVICE	TYPE OF SERVICE	VISIT DATE	SERVICES DESCRIPTION	CHARGES	PAYMENTS & ADJ.	BALANCE
Jamie Sample	Parkview Regional Medical Center & Affil	Outpatient	0/0/20	Account # <b>500001234567891</b>	\$00,000.00	\$-00,000.00	\$0,000.00
Physicians				<b>FINAL NOTICE</b>			<b>\$000.00</b>

**QUESTIONS?**

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