**MAKE CHECKS PAYABLE TO:**

PATIENT CARE
TEACHING
RESEARCH
CSG
CHILDREN'S SPECIALTY GROUP

Save time. Pay online!
**Pay your bill online at www.csgdocs.com**
Enter your online bill pay code:

See reverse side to make a payment by credit card or check.

| PAYMENT DUE DATE | PATIENT RESPONSIBILITY |
| --- | --- |
| | |

| ACCOUNT NUMBER | STATEMENT DATE |
| --- | --- |
| | |

**ADDRESSEE:**

**REMIT TO:**

☐ 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 | PROC CODE | DESCRIPTION | CHARGES | CREDITS | INSURANCE BALANCE | PATIENT BALANCE |
| --- | --- | --- | --- | --- | --- | --- |
| | | | | | | |

**SAVE A STAMP or receive an e-statement to pay on-line! Go to www.csgdocs.com**
**Questions regarding your statement? Email us at CSG.BILLING@CHKD.ORG**

| ACCOUNT # | ACCOUNT BALANCE | PENDING INSURANCE | PATIENT BALANCE | TOTAL DUE: |
| --- | --- | --- | --- | --- |
| | | | | |

ACCOUNT NAME

**If we do not have your insurance information on file, please call us at 757-668-7200**

Important Message Regarding Your Account

PLEASE UPDATE ANY INFORMATION THAT HAS CHANGED SINCE YOUR LAST STATEMENT

IF PAYING BY CREDIT CARD, FILL OUT BELOW

VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS ☐

CARD NUMBER

AUTHORIZATION CODE:
(usually last 3 or 4 digits on back of card in signature line)

SIGNATURE

EXP. DATE

☐ PAYING BY CHECK

SHOW AMOUNT PAID HERE $

ADDRESS CORRECTION

COMPLETE THIS SECTION IF YOUR ADDRESS ON REVERSE SIDE IS INCORRECT

NAME

ADDRESS

CITY

STATE, ZIP

PRIMARY INSURANCE COMPANY NAME

INSURANCE COMPANY'S ADDRESS

CITY | STATE | ZIP

POLICY HOLDER NAME | HOLDER'S DOB | RELATIONSHIP TO INSURED

INSURED'S ID NUMBER | GROUP PLAN NUMBER

SECONDARY INSURANCE COMPANY NAME

INSURANCE COMPANY'S ADDRESS

CITY | STATE | ZIP

INSURED'S ID NUMBER | GROUP PLAN NUMBER

**How Much Do I Really Owe?**

You are responsible for the amount listed in the box PATIENT BALANCE. As every insurance plan is different, if you disagree with how your insurance paid on your account, please contact them prior to contacting our office.

**What if I cannot pay in full?**

Please call the practice's patient account representative at (757) 668-7200 weekdays 8:00 a.m. until 4:00 p.m. Monday - Friday.

**Co-Pay:**

A dollar amount contracted between you and your insurance carrier, due at time of service.

**Co-Insurance:**

A percentage of the insurance benefits that you are responsible for.

**Deductible:**

A yearly dollar amount that you are responsible for based on the type of coverage you have selected with your insurance company.

**Adjustment:**

A contractual agreement that has been made between our Doctor and your insurance company.

**FOR QUESTIONS OR CONCERNS REGARDING YOUR DEDUCTIBLE, COPAY, CO-INSURANCE OR NON COVERED INSURANCE, PLEASE CALL YOUR INSURANCE COMPANY WHICH IS LOCATED ON YOUR INSURANCE CARD.**