Michigan Spine and Brain Surgeons

Responsible Party: Testecw Testecw

Responsible Party ID: 0001

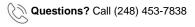
Summary (as of 12/10/2021)

Total Charges: \$250.00
Insurance & Adjustments: - \$0.00
Previously Paid: - \$0.00

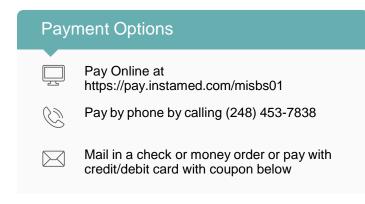
Total Balance \$250.00

detailed summary on next page

Your Statement



Thank you for choosing Michigan Spine and Brain Surgeons for your healthcare needs. Insurance has processed your claim and the balance is now your responsibility. The outstanding balance is now due. Please pay this amount in full. If you have questions please call our Customer Service Department at (248) 453-7838.



Messages

We have tried to contact you by text messages and/or phone calls on multiple occasions. This is your final statement. Please address this balance before your account is transferred to collections.



Pay Your Bill Online!

Go to https://pay.instamed.com/misbs01 now to make your payment!

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If you have questions about your bill, payment plans or concerns, please call Customer Service at: (248) 453-7838. Our hours are Monday - Friday, 7:00am - 7:00pm CST.

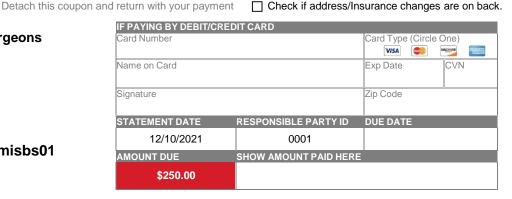
Michigan Spine and Brain Surgeons 22250 PROVIDENCE DRIVE SUITE 601

SUITE 601 SOUTHFIELD, MI 48075



Pay Online at https://pay.instamed.com/misbs01 Your eStatement ID: Q47TY868

Testecw Testecw 123456 Any Street Beverly Hills, CA 90210



PLEASE MAKE CHECKS PAYABLE TO:

Michigan Spine and Brain Surgeons 22250 PROVIDENCE DRIVE SUITE 601 SOUTHFIELD, MI 48075

Responsible Party: Testecw Testecw

Responsible Party ID: 0001

Your Statement Continued

DATE	DESCRIPTION		CHARGE	PMT/ADJ	TOTAL				
Testecw Testecw 0001 - (Bono, DO, Peter I.)									
12/10/2021	Existing Pt Level 4 Moderate Comple	exity	\$250.00						
			\$250.00	- \$0.00	\$250.00				
Total Bala					¢250.00				
Total Bala	ince				\$250.00				
TOTAL BAL \$250.00		30-60 Days \$0.00	60-90 Day \$0.00	'S	90+ Days \$0.00				
Ψ230.00	φ250.00	ψ0.00	φυ.υυ		ψ0.00				

If any of the following has changed since your last statement, please indicate

Your Name (Last, First, Middle Initial)		Date of Birth	Your PRIMARY Insurance Company's Name			
Address			Primary Insurance Company's Address			
City	State	Zip	City	State	Zip	
ephone Social Security #			Policyholder Name	Date of Birth	Sex	
Employer's Name Telephone			Policyholder's ID Number	Group Plan Number		
Employer's Address			Your SECONDARY Insurance Company's Name			
City	State	Zip	Secondary Insurance Company's Address			
Please Indicate if Applicable: Auto Accident Worker's Compensation		City	State	Zip		
Date of Injury			Policyholder Name	Date of Birth	Sex	
			Policyholder's ID Number	Group Plan Number		