WINCHESTER PEDIATRIC CLINIC
190 CAMPUS BLVD STE400
WINCHESTER VA 22601
PERSONAL & CONFIDENTIAL

RETURN SERVICE REQUESTED

005993
0101

9796 5372
STMT DATE: 07/27/17 JAYANNA ALSBERRY

IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.

☐ MASTERCARD ☐ VISA ☐ DISCOVER

CARD NUMBER	VERIFICATION #
CARDHOLDER NAME	EXP. DATE
SIGNATURE	

ACCOUNT NO.	DUE DATE	AMOUNT DUE	SHOW AMOUNT PAID
51395	Upon Receipt	$62.27	

Pay online now at www.PayMyDoctor.com Free,Secure, Easy Use Clinic ID 9796

ERIKA R ALFORD
134 JAMESTOWN RD
SUMMIT POINT, WV 25446-3585

WINCHESTER PEDIATRIC CLINIC
190 CAMPUS BLVD STE400
WINCHESTER VA 22601-2872

655317A (PC1)

STATEMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

PAGE	STATEMENT DATE	DUE DATE	OFFICE PHONE NUMBER	ACCOUNT #	AMOUNT DUE
1	07/27/17	Upon Receipt	(540) 667-1727	51395	$62.27

DATE	PROVIDER / REFERRING PROVIDER EXPLANATION OF ACTIVITY	CHARGES & DEBITS	INSURANCE PENDING	PAYMENTS & CREDITS	BALANCE
	DAMRON				
07/10/17	CPT: 99213 SICK VISIT, EST, INTERMED SHERAYA DX: J20.9 - ACUTE BRONCHITIS, UNSPECI	$95.00			
07/12/17	CIGNA # 1065881 Filed		$0.00		
07/19/17	PMT CIGNA c# 10658811			$0.00	
07/19/17	W/O CIGNA c# 10658811			-$32.73	
07/19/17	Deductible 62.27				
******	Visit Totals:	$95.00	$0.00	-$32.73	$62.27

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	PATIENT BALANCE PAY THIS AMOUNT
$62.27				$62.27	$0.00	$62.27

MESSAGE:
$20 FEE- IF APPT NOT CANCELED
24 HRS IN ADVANCE--CLINIC HRS.
6:30-7:30 PM EVERY NIGHT-SAT/
SUN/HOLIDAY 9:30-10:30AM +PM

SEND INQUIRIES TO:
WINCHESTER PEDIATRIC CLINIC
190 CAMPUS BLVD STE400
WINCHESTER VA 22601-2872

IRS #: 541511229
(540) 667-1727

0000002355-A

15860-ALLSCYC-168850-1215558132-P; 5825337-1-776; 38624163-1; 1

The purpose of this communication is to collect a debt, and any information obtained will be used for that purpose.

Foot Care Center PLC
PO Box 1804
Winchester, VA 22604

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
☐ VISA ☐ MASTERCARD		
CARD NUMBER	NAME (exactly as it appears on the card)	
SIGNATURE	EXP DATE	CVV

ACCOUNT NO	DUE DATE	PAY THIS AMOUNT
410301	08/11/2017	$40.00

Statement Date: 07/12/2017 — SHOW AMOUNT PAID HERE $

MDG2012 00001580 1 AB .403 1
ERIKA ALFORD
PO BOX 241
SUMMIT POINT WV 25446-0241

Paid 8/9/17

Foot Care Center PLC
PO Box 1804
Winchester VA 22604

St# 012 620 161 ☐ Please check box if above address is incorrect or insurance information has changed and mark change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN THE ENCLOSED ENVELOPE

Foot Care Center PLC

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

STATEMENT

STATEMENT DATE	STATEMENT PERIOD	ACCOUNT NO.	ACCOUNT NAME
07/12/2017	thru 07/12/2017	410301	ERIKA ALFORD

Date	Code	Patient	Description	Provider	Charge	Credit	Balance
05/12/17	**99202**	**ERIKA**	**OFFICE OUTPT NEW 20 MINUTES**	**Davis**	**$120.00**		
05/12/17	**10061**	**ERIKA**	**DRAINAGE OF SKIN ABSCESS**	**Davis**	**$325.00**		
05/24/17			PAYMENT INS CK##170523190403811			$0.00	
05/24/17			W/O CIGNA			-$194.43	
05/24/17			APPLIED TO DEDUCTIBLE $250.57			$0.00	
05/26/17			PAYMENT CC			-$150.00	
07/05/17			PAYMENT CC			-$100.20	$0.37
05/26/17	**99212**	**ERIKA**	**OFFICE OUTPT EST 10 MIN**	**Davis**	**$75.00**		
06/07/17			PAYMENT INS CK##170606190024503			*$0.00*	
06/07/17			W/O CIGNA			-$35.37	
06/07/17			APPLIED TO DEDUCTIBLE $39.63			$0.00	$39.63

Balances	Current	31-60
Patient	$0.00	$40.00
Insurance	$0.00	$0.00
Total	$0.00	$40.00

Please Pay This Amount: $40.00

Last Payment of $100.20 received 07/05/2017

PAYMENT DUE UPON RECEIPT. BILLING QUESTIONS PLEASE CALL (540)504-0326 OR (800) 835-1945 FROM 8AM-4PM OR SUBMIT BILLING INQUIRIES TO: BILLING@JD-MATTHEWS.COM. PLEASE INCLUDE THE PRACTICE NAME, PATIENT NAME AND DATE OF BIRTH, ACCOUNT NUMBER AND YOUR CONTACT INFORMATION.

MAKE CHECKS PAYABLE TO:

Foot Care Center PLC
PO Box 1804
Winchester, VA 22604

Account: 410301

Statement #: 012 620 161
YNNNNN 01 01 001580 001650P

If we do not have your information, or if any of the following has changed since your last statement, please indicate...

Responsible Party

Your Name (Last, First, Middle Initial)		Date of Birth
Address		
City	State	Zip
Telephone	Cell Phone	
Social Security #	Email	

Employer

Employer's Name	Telephone
Employer's Address	
City	State Zip

Primary Insurance

Insurance Company Name			
Insurance Company Address			
City	State	Zip	
Policyholder Name	Date of Birth	Sex	Relation
Policyholder's ID Number	Group Plan Number		Effective Date

Secondary Insurance

Insurance Company Name			
Insurance Company Address			
City	State	Zip	
Policyholder Name	Date of Birth	Sex	Relation
Policyholder's ID Number	Group Plan Number		Effective Date