Account Number located here

Statement

PATIENT NAME		
Leesa Test		
BILL DATE	**ACCT**	**AMOUNT PAID**
02/03/2023	176071	

IF PAYING BY CREDIT, FILL OUT BELOW.
CHECK CARD USED

[ ] MASTER CARD **[ ] VISA** **[ ] DISCOVER**

CARD NUMBER **AMOUNT PAID**

SIGNATURE: **EXP.DATE:**

AMOUNT ENCLOSED:

Leesa Test
[redacted]

THIS IS A STATEMENT OF SERVICES RENDERED BY PHYSICIAN(S) WHO ARE MEMBERS OF:

FishHawk - OMGTB
PO BOX 850001 DEPT 8272
Orlando FL 32885-8272
813-681-4272

DATE OF SERVICE	DESCRIPTION OF SERVICE		AMOUNT
11/08/2021	[redacted]		
11/08/2021	99214 Office Visit- Est Pt.- Level 4	100.00	
11/08/2021	73564 X-RAY EXAM- KNEE MIN 4 VIEWS	100.00	
02/03/2023	Your Balance Due On These Services		
	Your Balance Due On These Services ...		200.00

DATE	PATIENT NAME	ACCT. NO.	PAY THIS AMOUNT	
02/03/2023	Leesa Test	176071		200.00
CURRENT	**30 DAYS**	**60 DAYS**	**90 DAYS**	**120+ DAYS**
0.00	0.00	0.00	200.00	0.00

This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services.

MAKE CHECK PAYABLE TO: ORTHOPAEDIC MEDICAL GROUP OF TAMPA BAY

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT