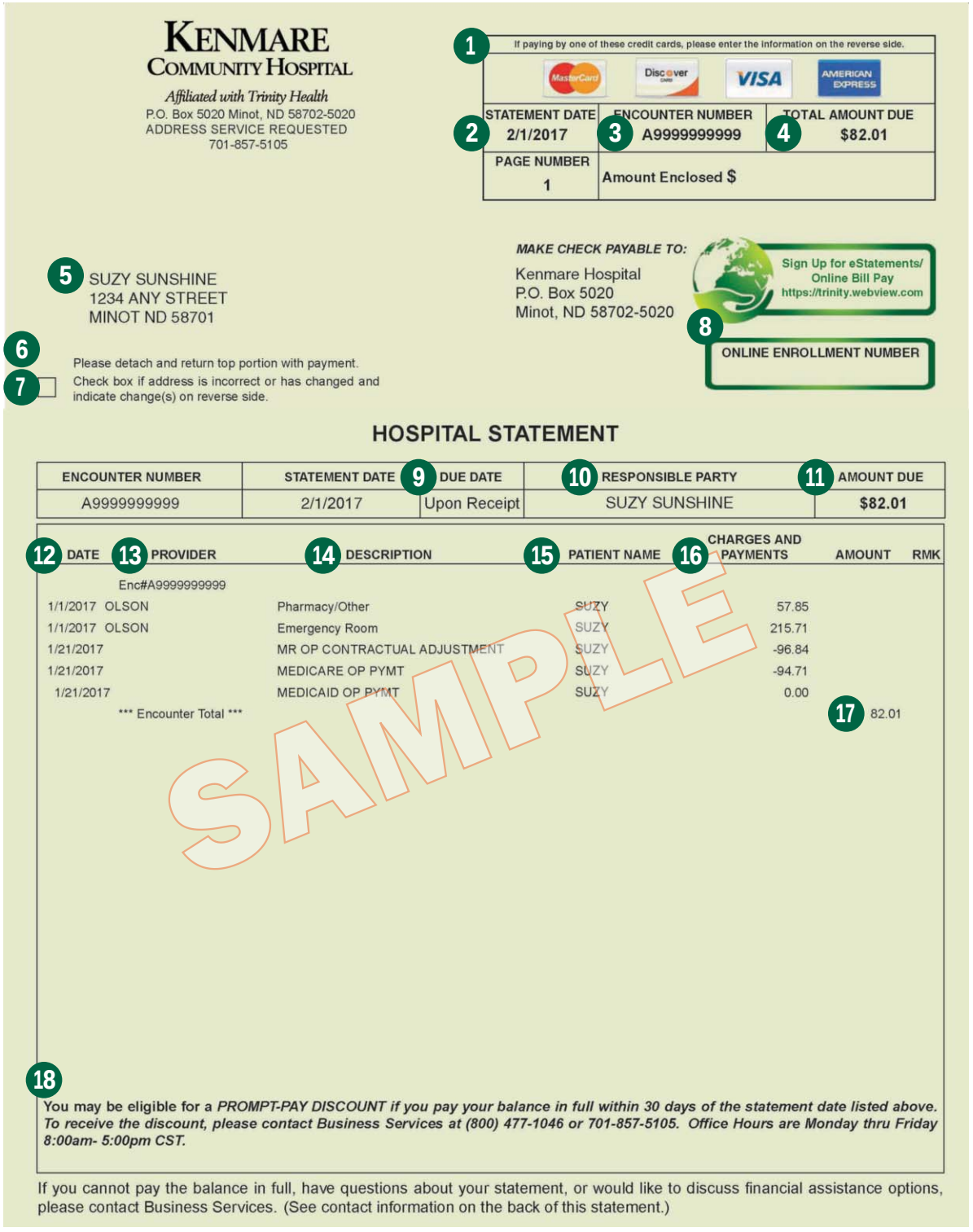
HOW TO READ YOUR STATEMENT

1. Credit Cards- We accept all major Credit Cards and Debit Cards including MasterCard, Visa, Discover and American Express (See reverse side of statement)
2. Statement Date- The date the statement was created
3. Encounter Number- This is the reference number for a particular visit. Please reference this number when contacting our office.
4. Total Amount Due- Amount due from you for this statement
5. Name and Address of Guarantor/Responsible Party
6. Remittance Portion- Tear on the perforation and return this portion of your statement with your payment. Keep the lower potion for your records.
7. Address Change- Check this box if information has changed. (See reverse side of statement)
8. eStatements- The link that provides information to register for online statements and to make payments online.
9. Due Date- Statement balances are due Upon Receipt
10. Responsible Party- Guarantor/Person responsible for the balance.
11. Amount Due-Balance due on this encounter
12. Date- Date on which services were provided
13. Provider- Provider who performed or ordered the services
14. Description- Description of services provided
15. Patient Name- Name of the patient who received services listed
16. Charges and Payments- Charges, payments and/or adjustments for this encounter
17. Encounter Total- Total amount of the charges for this visit
18. Our contact information to inquire about financial assistance or ask questions about your account.



KENMARE COMMUNITY HOSPITAL
Affiliated with Trinity Health
P.O. Box 5020 Minot, ND 58702-5020
ADDRESS SERVICE REQUESTED
701-857-5105

1 If paying by one of these credit cards, please enter the information on the reverse side.

MasterCard Discover VISA AMERICAN EXPRESS

2 STATEMENT DATE	3 ENCOUNTER NUMBER	4 TOTAL AMOUNT DUE
2/1/2017	A9999999999	$82.01
PAGE NUMBER 1	Amount Enclosed $	

5 SUZY SUNSHINE
1234 ANY STREET
MINOT ND 58701

MAKE CHECK PAYABLE TO:
Kenmare Hospital
P.O. Box 5020
Minot, ND 58702-5020

Sign Up for eStatements/ Online Bill Pay
https://trinity.webview.com

8 ONLINE ENROLLMENT NUMBER

6 Please detach and return top portion with payment.

7 ☐ Check box if address is incorrect or has changed and indicate change(s) on reverse side.

HOSPITAL STATEMENT

ENCOUNTER NUMBER	STATEMENT DATE	9 DUE DATE	10 RESPONSIBLE PARTY	11 AMOUNT DUE
A9999999999	2/1/2017	Upon Receipt	SUZY SUNSHINE	$82.01

12 DATE	13 PROVIDER	14 DESCRIPTION	15 PATIENT NAME	16 CHARGES AND PAYMENTS	AMOUNT	RMK
	Enc#A9999999999					
1/1/2017	OLSON	Pharmacy/Other	SUZY	57.85		
1/1/2017	OLSON	Emergency Room	SUZY	215.71		
1/21/2017		MR OP CONTRACTUAL ADJUSTMENT	SUZY	-96.84		
1/21/2017		MEDICARE OP PYMT	SUZY	-94.71		
1/21/2017		MEDICAID OP PYMT	SUZY	0.00		
	*** Encounter Total ***				17 82.01	

SAMPLE

18 You may be eligible for a *PROMPT-PAY DISCOUNT if you pay your balance in full within 30 days of the statement date listed above. To receive the discount, please contact Business Services at (800) 477-1046 or 701-857-5105. Office Hours are Monday thru Friday 8:00am- 5:00pm CST.*

If you cannot pay the balance in full, have questions about your statement, or would like to discuss financial assistance options, please contact Business Services. (See contact information on the back of this statement.)