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 a 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 portion for your records.
7. Address Change - Check this box if information has changed. (See the 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 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.

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 ACCOUNT NUMBER	4 AMOUNT
3/8/2022	X1234567890	$10.17
STATEMENT NBR 1	Indicate Amount Paid $	

8 Online Bill Pay: https://www.personapay.com/trinity

5
Suzy Q Sunshine
123 4th St SW
Minot, ND 58701

MAKE CHECK PAYABLE TO:
Trinity Hospitals
P.O. Box 5020
Minot, ND 58702-5020

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

3 ENCOUNTER NUMBER	2 STATEMENT DATE	9 DUE DATE	10 RESPONSIBLE PARTY	11 AMOUNT DUE
X1234567890	3/8/2022	Upon Receipt	SUZY Q SUNSHINE	$10.17

12 DATE	13 PROVIDER	14 DESCRIPTION	15 PATIENT NAME	16 CHARGES AND PAYMENTS	AMOUNT	RMK
	Enc#X1234567890					
10/13/2021	COOMBS	Clinic Facility Fee	SUZY	135.00		
2/9/2022		MR OP CONTRACTUAL ADJUSTMENT	SUZY	-84.13		
2/9/2022		MEDICARE OP PYMT	SUZY	-40.70		
	*** Encounter Total ***				10.17	

17

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.)