Spartanburg Regional Healthcare System
PO Box 3475
Toledo, OH 43607-0475

PATIENT NAME	GUARANTOR ACCOUNT
Bacon, Chris P	**198**
PATIENT BALANCE	AMOUNT PAID
$108.55	$
DATE DUE	STATEMENT DATE
10/10/2023	09/10/2023

VISA

Card Number Exp. Date

Signature security code

Spartanburg Regional Healthcare System

Patient Financial Services
101 East Wood Street
Spartanburg, SC 29303-3153

Account Summary

Guarantor Name	Bacon, Chris P "Crispy"
Patient Name	Bacon, Chris P
Medical Record Number	10000064
Statement Date	09/10/2023
Amount Due	**$108.55**

Online Bill Pay
Online bill pay is available 24 hours a day, seven days a week.
To view your account information and pay your bill online, visit **SpartanburgRegional.com/BillPay.**

For payment options, billing questions, or insurance updates Please contact Customer Service:
864-596-1001 or 800-281-5346
8:00am - 5:00pm, Monday - Friday

***Make check payable to**
Spartanburg Regional Healthcare System
PO Box 743829
Atlanta, GA 30374-3829

*Please include the guarantor number on your check
*Please include your phone number on your check
*Enclose the above payment stub with your payment
*The above amount due is liquidated and not subject to dispute. SRHS expects full payment. The acceptance of partial payment does not waive SRHS' right to collect full payment, notwithstanding any contrary language accompanying partial payment.

Important News

If you are experiencing a financial hardship that is impacting your ability to meet your healthcare financial obligations, please contact us at 1-800-281-5346 for assistance.
Please refer to the back of this statement for a summary of each account.

About Your Statement

Thank you for choosing Spartanburg Regional Healthcare System and its affiliates as your healthcare provider. This statement is for services delivered by Spartanburg Regional Healthcare System's affiliated facilities and clinics, and our employed providers. If other medical providers assisted in your care, you will receive an additional statement from each of them.

You may obtain an itemized bill upon request.
Patients have the right to request an audit of charges. Request must be made within 90 days of your first statement.

Your account is past due and in 30 days from this notice will be sent to our collection agency that may perform extraordinary collection actions. You may pay by cash, check, credit, or money order. If you have any questions about this statement or if you would like to apply for financial assistance please contact Customer Service at (800) 281-5346.

Do We Have Your Insurance Information?

Accurate insurance information helps ensure prompt payments by your insurance company. If you were unable to provide your insurance information or if different than shown on the front of this page, please complete the section below and return this page or call our office. Thank You!

Mail this stub to the address on reverse side.

1. Primary Insurance: ☐ Medicare ☐ HMO ☐ PPO ☐ Other

Insured Name _____

Insurance Name _____

Address _____

City/St _____ Zip_____ Phone _____

Group/Plan _____ ID# _____

Employer _____

Secondary Insurance: ☐ Medicare ☐ HMO ☐ PPO ☐ Other

Insured Name _____

Insurance Name _____

Address _____

City/St _____ Zip _____ Phone _____

Group/Plan _____ ID# _____

Employer _____

I authorize the hospital to submit any or all medical data to my insurance co and authorize the assignment of any benefits or payments to the hospital for charges not covered by this authorization. Please return with copies of the front and back of your insurance card(s).

Signed _____ Date _____

CHANGE OF ADDRESS

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Spartanburg Regional Healthcare System

Account Detail

Guarantor Name	Bacon, Chris P
Guarantor Account	198

Patient - Bacon, Chris P **Service Date - 9/26/2019** **MGC Family Medicine Duncan** **Acct # 1000006330**

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
09/26/2019	PR Office Outpatient Visit 15 Minutes	167.00			
	Self-Pay Discount - 02/14/2023			58.45	
	Your Responsibility				$108.55
	Totals	167.00	0.00	58.45	$108.55
	Balance Due				$108.55

* indicates the account is on a payment plan