This section tells you the total amount owed for the services you received.
The amount that your insurance paid and what you are responsible for. The amount you owe will be listed next to "Please Pay This Amount."
The itemized charges are listed on the reverse side.

Charge Summary
Total Charges: $27,641.83
Est Ins Coverage 1: $0.00
Est Ins Coverage 2: $0.00
Est Ins Coverage 3: $0.00
Est Ins Coverage 4: $0.00
Please Pay This Amt: $10,890.62

Contact Us
For questions, call customer service at: (504) 897-8350.

Confirm that the primary and secondary insurance information you provided is correct.
Touro files health insurance claims directly with your primary payer and, if appropriate, your secondary insurance payer. Any co-payments and/or outstanding balances not paid by your insurance payer will be billed to you directly.

Corrections or questions? Write changes on the form on the reverse of the bill and mail it to Touro or call the Patient Billing Office at (504) 897-8350.

Please pay this amount by:

AMOUNT DUE: The amount listed here is what you are responsible for paying Touro.

Have a question or want to set up a payment plan? Call the Patient Billing Office at (504) 897-8350.
Paying by check? Make checks payable to Touro Infirmary.
## Account Summary

Patient Name: Last, First  
Statement Date: 04/29/11  
Service Date(s): 04/18/11 - 04/21/11  
Account Number: 12345678900  
Medical Record Number:  
Please Pay This Amt: $10,890.62

## Charge Information

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Description of Hospital Services</th>
<th>Code</th>
<th>Total Charges</th>
<th>Est Coverage Ins Co No 1</th>
<th>Est Coverage Ins Co No 2</th>
<th>Est Coverage Ins Co No 3</th>
<th>Est Coverage Ins Co No 4</th>
<th>Patient Amount</th>
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<tbody>
<tr>
<td>SUMMARY OF CHARGES</td>
<td>R&amp;C SEMI-PR 3DAYS AT1090.00</td>
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<td>1139.00</td>
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<td>EMERGENCY ROOM</td>
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</table>

This section lists all the services you received and the cost for each. The total charges are listed in the “Charge Summary” section on the front of the statement.

YOU OWE $10890.62

SUMMARY OF PAY/ADJ   0111 $SPD SPECIAL D 8001004 00116335.91-    16335.91-

TOTALS $10890.62

Please use this space to make corrections to your address or insurance information:

Name: 
Account No: 
Phone:
Address: 
Business Phone: 
Employer: 
Employer Address: 
Insurance Company: 
Effective Date: 
Insurance Company Address: 
Phone: 
Insurance Policy or Contact No: 
Group No: 
Policy Holder's Name: 
Phone: 
Policy Holder's Date of Birth: 
Policy Holder's Gender: M F 
Policy Holder's Social Security No: 
Patient's Relationship to Insured: Self Spouse Child Other