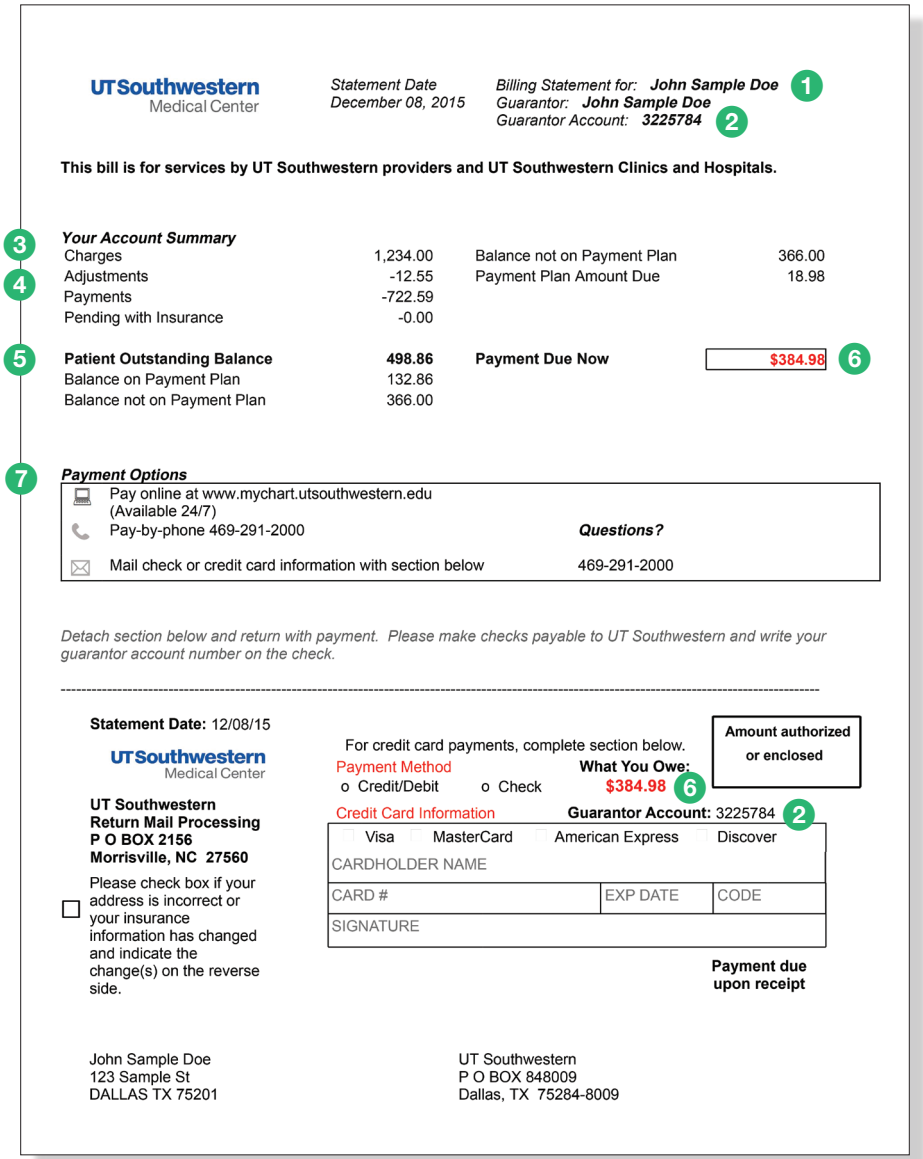
Reading Your Statement

UT Southwestern Medical Center

1. **Patient's name and the name of the Guarantor** (the person legally responsible for paying the bill).
2. **Guarantor account number**—This is your financial account with UT Southwestern. Please refer to this number if you contact us with questions.
3. **Charges**—total charged by UT Southwestern for health care services rendered to the patient
4. **Adjustments and payments**—credits to your account for any payments your insurance company or you have already made (such as copays or coinsurance); any contractual adjustments given by your insurance company; and any other discounts made to your account.
5. **Patient Outstanding Balance**—total amount that you (the guarantor) owe UT Southwestern
6. **Payment Due Now**—portion of your total balance that you (the guarantor) owe this month.
7. **Payment Options**—you can pay your bill via MyChart or over the phone with a credit or debit card, or you can pay by mail with a credit or debit card or personal check.



UT Southwestern Medical Center

Statement Date
December 08, 2015

Billing Statement for: ***John Sample Doe*** (1)
Guarantor: ***John Sample Doe***
Guarantor Account: ***3225784*** (2)

This bill is for services by UT Southwestern providers and UT Southwestern Clinics and Hospitals.

(3) ***Your Account Summary***

Charges	1,234.00	Balance not on Payment Plan	366.00
(4) Adjustments	-12.55	Payment Plan Amount Due	18.98
Payments	-722.59		
Pending with Insurance	-0.00		
(5) **Patient Outstanding Balance**	**498.86**	**Payment Due Now**	$384.98 (6)
Balance on Payment Plan	132.86		
Balance not on Payment Plan	366.00		

(7) ***Payment Options***

Pay online at www.mychart.utsouthwestern.edu (Available 24/7)
Pay-by-phone 469-291-2000 — ***Questions?***
Mail check or credit card information with section below — 469-291-2000

Detach section below and return with payment. Please make checks payable to UT Southwestern and write your guarantor account number on the check.

Statement Date: 12/08/15

UT Southwestern Medical Center

UT Southwestern
Return Mail Processing
P O BOX 2156
Morrisville, NC 27560

☐ Please check box if your address is incorrect or your insurance information has changed and indicate the change(s) on the reverse side.

For credit card payments, complete section below.

Payment Method: o Credit/Debit o Check

What You Owe: $384.98 (6)

Amount authorized or enclosed

Credit Card Information — **Guarantor Account:** 3225784 (2)

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

CARDHOLDER NAME

CARD # | EXP DATE | CODE

SIGNATURE

Payment due upon receipt

John Sample Doe
123 Sample St
DALLAS TX 75201

UT Southwestern
P O BOX 848009
Dallas, TX 75284-8009

Reading Your Statement

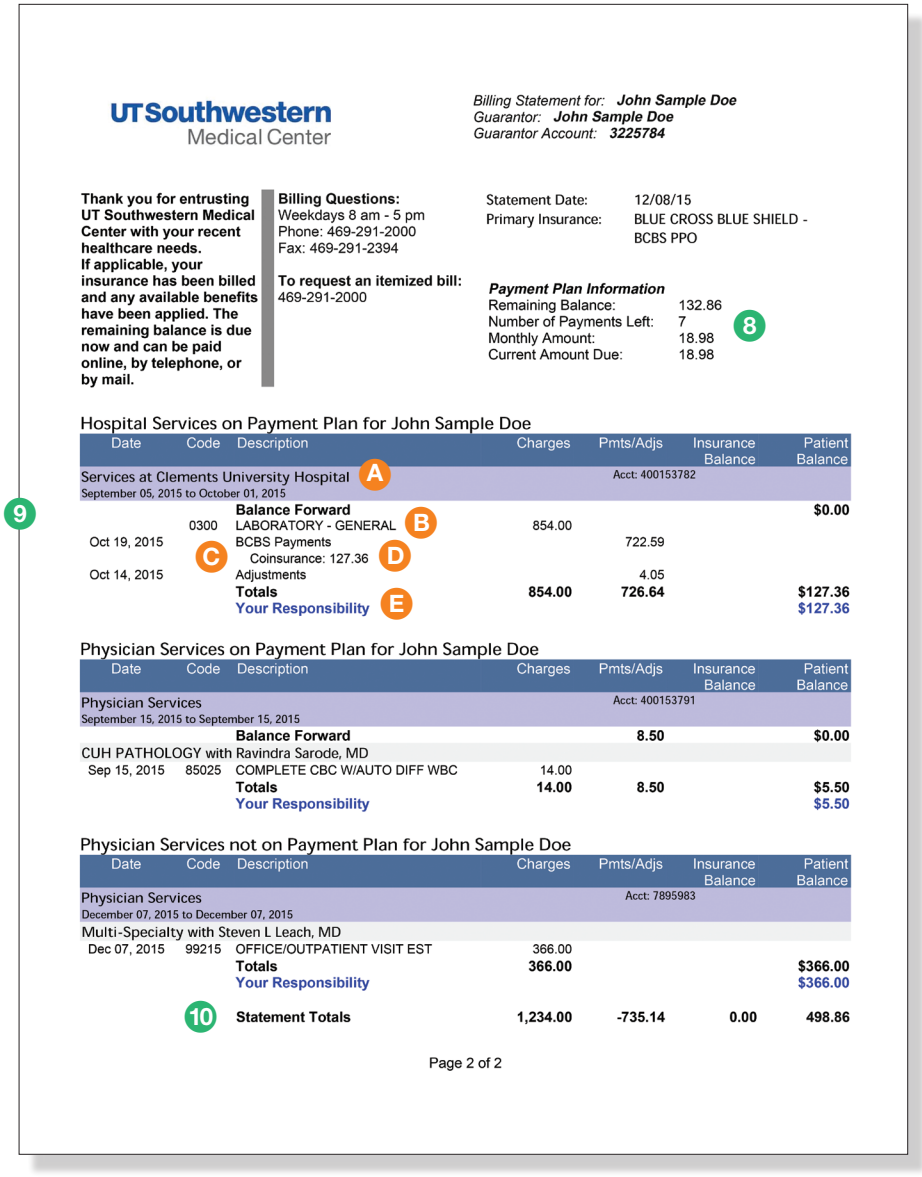
UT Southwestern Medical Center

8 **Payment Plan Information**—if you are paying your balance on an installment plan, the summary of that plan is listed here.

9 **Service Details**—these sections list the services provided by UT Southwestern and detail the charges, adjustments and discounts, and payments for each.

- A Place of the service and date range of the billing transactions for that service
- B Health care service that was provided by UT Southwestern
- C Adjustments, discounts or payments by the patient's insurance company
- D Payments made by you (guarantor); this might include your copay, coinsurance, or deductible payment(s)
- E Your Responsibility—the amount you (guarantor) owe for that specific service. This is NOT your total balance due.

10 **Statement Totals**—this is the sum total of each column, including total charges (shown as 3 on the first page), total payments and adjustments (shown as 4 on the first page), and total patient balance (shown as 5 on the first page).



UT Southwestern Medical Center

Billing Statement for: ***John Sample Doe***
Guarantor: ***John Sample Doe***
Guarantor Account: ***3225784***

Thank you for entrusting UT Southwestern Medical Center with your recent healthcare needs. If applicable, your insurance has been billed and any available benefits have been applied. The remaining balance is due now and can be paid online, by telephone, or by mail.

Billing Questions:
Weekdays 8 am - 5 pm
Phone: 469-291-2000
Fax: 469-291-2394

To request an itemized bill:
469-291-2000

Statement Date: 12/08/15
Primary Insurance: BLUE CROSS BLUE SHIELD - BCBS PPO

Payment Plan Information
Remaining Balance: 132.86
Number of Payments Left: 7
Monthly Amount: 18.98
Current Amount Due: 18.98

8

Hospital Services on Payment Plan for John Sample Doe

Date	Code	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
Services at Clements University Hospital (A)				Acct: 400153782		
September 05, 2015 to October 01, 2015						
		Balance Forward				**$0.00**
	0300	LABORATORY - GENERAL (B)	854.00			
Oct 19, 2015		BCBS Payments (C)		722.59		
		Coinsurance: 127.36 (D)				
Oct 14, 2015		Adjustments		4.05		
		Totals	**854.00**	**726.64**		**$127.36**
		Your Responsibility (E)				$127.36

Physician Services on Payment Plan for John Sample Doe

Date	Code	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
Physician Services				Acct: 400153791		
September 15, 2015 to September 15, 2015						
		Balance Forward		**8.50**		**$0.00**
CUH PATHOLOGY with Ravindra Sarode, MD						
Sep 15, 2015	85025	COMPLETE CBC W/AUTO DIFF WBC	14.00			
		Totals	**14.00**	**8.50**		**$5.50**
		Your Responsibility				$5.50

Physician Services not on Payment Plan for John Sample Doe

Date	Code	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
Physician Services				Acct: 7895983		
December 07, 2015 to December 07, 2015						
Multi-Specialty with Steven L Leach, MD						
Dec 07, 2015	99215	OFFICE/OUTPATIENT VISIT EST	366.00			
		Totals	**366.00**			**$366.00**
		Your Responsibility				$366.00
10		**Statement Totals**	**1,234.00**	**-735.14**	**0.00**	**498.86**

9

Page 2 of 2