RETURN MAIL ONLY:

Accelacare Physical Therapy LLC
101 E Fulton St
Garden City KS 67846

DUE UPON RECEIPT	$170.00	STATEMENT DATE	9/20/2024

See reverse side for payment by credit card or check.

ADDRESSEE:

Patient Name
Patient Address
GARDEN CITY, KS 67846-5249

MAKE CHECKS PAYABLE AND REMIT TO:

ACCELACARE PHYSICAL THERAPY LLC
101 E Fulton St
GARDEN CITY KS 67846

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

STATEMENT

Acct #: A796406554

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

9/20/2024

DATE OF SERVICE	PROVIDER	LOCATION OF SERVICES	CHARGES	PAYMENTS/ADJ.	PATIENT RESPONSIBILITY
06/25/2024	Reich	Accelacare Physical Therapy	$166.00	-$149.00	$17.00
07/02/2024	Reich	Accelacare Physical Therapy	$180.00	-$163.00	$17.00
07/03/2024	Sarmiento	Accelacare Physical Therapy	$135.00	-$118.00	$17.00
07/07/2024	Akinyode	Accelacare Physical Therapy	$170.00	-$153.00	$17.00
07/15/2024	Akinyode	Accelacare Physical Therapy	$170.00	-$153.00	$17.00
07/21/2024	Reich	Accelacare Physical Therapy	$180.00	-$163.00	$17.00
07/25/2024	Reich	Accelacare Physical Therapy	$170.00	-$153.00	$17.00
08/03/2024	Reich	Accelacare Physical Therapy	$180.00	-$163.00	$17.00
08/05/2024	Sarmiento	Accelacare Physical Therapy	$180.00	-$163.00	$17.00
08/12/2024	Reich	Accelacare Physical Therapy	$135.00	-$118.00	$17.00

MESSAGE:

* Payments, Adjustments and transfers reflect activity for August 2024
* THE AMOUNT DUE IS AMOUNT INDICATED ON THE LAST PAGE OF THIS STATEMENT.

DUE UPON RECEIPT	$170.00
STATEMENT DATE:	9/20/2024
ACCOUNT NUMBER:	A796406554

For Billing Questions please call us at : (620) 271-0700

189946576

PLEASE UPDATE ADDRESS INFORMATION IF IT HAS CHANGED SINCE YOUR LAST STATEMENT

ABOUT YOU

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE

( )

MARITAL STATUS

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME

TELEPHONE

( )

EMPLOYER'S ADDRESS CITY STATE ZIP

PAY BY CREDIT CARD

☐ MasterCard ☐ VISA ☐ AMEX ☐ DISCOVER CARD

CARD NUMBER

AUTHORIZATION CODE

SIGNATURE

EXP. DATE

ACCOUNT #

DUE DATE

PATIENT RESPONSIBILITY

SHOW AMOUNT PAID HERE $