

At Great Falls Clinic,
we continually strive to improve
our service to you, our valued patient.
We have developed an improved
statement that we believe will
better meet your needs.

We have made every effort to make
changes that will answer the most
frequently asked questions and is
easy to read.

A sample with a brief explanation of
our new statement is included in
this brochure.

QUESTIONS?

Our Professional Patient Accounts Staff
is available to answer your questions

Monday through Friday

from

8:00am to 5:00pm

at

406-771-3175

or toll free

1-866-842-5429

Our Locations

The Great Falls Clinic offers access to
comprehensive healthcare at locations in
Great Falls, Helena, Butte, Choteau and
Fairfield. Our locations include:

- Great Falls Clinic - Main Clinic
- Great Falls Clinic - Northwest Clinic
- Great Falls Clinic Surgery Center
- Great Falls Clinic Specialty Center
- Great Falls Clinic - Marketplace
- Great Falls Clinic - Immediate Care Center
- Clinic Cancer Care
- Central Montana Hospital
- Helena Physicians' Clinic
- Mercury Street Medical Group (Butte)
- Focused MedCare (Butte)
- Choteau Clinic
- Fairfield Clinic




the team behind your team



Keys to Understanding Your Great Falls Clinic Statement

Numbered areas point out where important information can be found on our newly formatted statement

- 1 Area to fill out when paying with a credit card
- 2 Patient account number
- 3 Date statement was printed
- 4 Amount due from patient
- 5 Date payment is due
- 6 Responsible party name and address
- 7 Description of account activities
- 8 Insurance payments/adjustments received
- 9 Patient payments/adjustments received
- 10 Back of statement; please make any address or insurance changes here
- 11 Patient Financial Services Policies; for more details on these policies, contact the GFC Business Office



Account Name
Philip Rohs

Statement Date 1/1/08 **Due Date** 1/31/08

Account Number 1234567 **Pay This Amount** \$93.93

Message
THE GREAT FALLS CLINIC IS PROUD TO WELCOME MERCURY STREET MEDICAL GROUP AND FOCUSED MEDICARE IN BUTTE, MONTANA TO OUR HEALTHCARE TEAM!

ADDRESSEE:
PHILIP ROHS
100 SOUTH OWASSO BLVD
GREAT FALLS, MT 59405

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Service Date	Patient Name	Provider	Description	Charges	Insurance Payments/Adjustments	Patient Payments/Adjustments	Patient Due
7/29/07	Philip E. Rohs	Dunklee	Office Visit Insurance Payment Patient Payment Check #4612 Patient Payment Check #4641	115.00	-11.17	-10.00 -10.00	83.83
7/30/07	Philip E. Rohs	Rethwill	Office Visit Insurance Payment	100.00	-90.00	0.00	10.00

VISIT US AT OUR WEBSITE — WWW.GFCLINIC.COM

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

1 IF PAYING BY CREDIT CARD, FILL OUT BELOW.

CARD NUMBER: _____ SIGNATURE CODE: _____

SIGNATURE: _____ EXP. DATE: _____

STATEMENT DATE: 8/01/07 ACCOUNT NUMBER: 1234567 PAY THIS AMOUNT: \$93.93 SHOW AMOUNT PAID HERE: \$

* M.C. DISCOVER & VISA Last 3 Digit Number on Back of Card 4 Digit Number on Front of Card AMERICAN EXPRESS DUE DATE 8/31/07 CHECK #


REMIT TO:
GREAT FALLS CLINIC
PO BOX 5012
GREAT FALLS, MT 59403-5012

12345670000001234567000000012345

Questions About Your Statement

Our professional Patient Accounts Staff will assist you with any questions concerning your Great Falls Clinic statement. Please call 406-454-2171 or toll free at 1-866-842-5429.

Please refer to the back of the statement for an explanation of patient responsibility, any address or insurance changes, and additional telephone numbers that may be helpful in resolving your accounts.



Explanation of Patient Responsibility

If you have provided us with complete and accurate insurance information, the Great Falls Clinic will file insurance claims for you, as a courtesy, with the understanding that you or your guarantor have full responsibility for payment of the bill.

The Great Falls Clinic does not accept responsibility for collecting your insurance claim or negotiating settlement on a disputed claim. The Great Falls Clinic requires monthly payment on all outstanding balances including liability insurance claims or legal suits. **You are responsible for payment on your account.**

If the Great Falls Clinic does not participate with your health plan or if you are uninsured, itemized charges will show on your billing statement within 30 days of the date of service. If the Great Falls Clinic is a participating provider with your health plan, the itemized charges will appear after your claim has been processed and there is a patient balance.

Payment is due on or before the due date unless you have made other arrangements with the Great Falls Clinic. Payment arrangements within our guidelines can be made by contacting our Patient Accounts staff. Accounts not paid in accordance with our guidelines, are subject to review for placement with our collection agency.

Checks returned for insufficient funds (NSF) will be assessed an additional \$20.00 fee per check. To avoid further collection action, the check amount and additional fee are due within ten (10) days of our NSF notice to you.

You may receive additional bills from the facility where you received your care or from other providers who rendered services. Please contact them directly if you have questions regarding their bills.

Questions Concerning This Statement

Our professional Patient Accounts staff will assist you with any questions concerning this statement. Our office hours are Monday through Friday 8:00AM to 5:00PM MST. We are physically located at 1400 29th Street South, Great Falls, Montana. Please contact our Business Office at (406) 771-3175 or (866) 842-5429.

If you prefer to contact us in writing, our mailing address is:
Great Falls Clinic, Patient Accounts, PO Box 5012, Great Falls, MT 59403-5012.

PLEASE UPDATE ANY INFORMATION THAT HAS CHANGED SINCE YOUR LAST STATEMENT

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)
ADDRESS _____
CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____
WORK TELEPHONE _____
CELL PHONE _____

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME _____ INSURANCE COMPANY'S PHONE _____

POLICY HOLDER'S NAME _____ POLICY HOLDER'S D.O.B. _____

PRIMARY INSURANCE COMPANY'S ADDRESS _____
CITY _____ STATE _____ ZIP _____

POLICY HOLDER'S ID NUMBER _____ GROUP PLAN NUMBER _____

YOUR SECONDARY INSURANCE COMPANY'S NAME _____ INSURANCE COMPANY'S PHONE _____

POLICY HOLDER'S NAME _____ POLICY HOLDER'S D.O.B. _____

SECONDARY INSURANCE COMPANY'S ADDRESS _____
CITY _____ STATE _____ ZIP _____

POLICY HOLDER'S ID NUMBER _____ GROUP PLAN NUMBER _____