

Harborview Medical Center  
PO Box 34570  
Seattle WA 98124-1570

Statement Date: 11/06/2018

CHRIS PATIENCE  
535 W 110TH ST APT 4D  
NEW YORK, NY 10025-2022

Summary for patient: CHRIS PATIENCE

Total Charges	\$2,075.00
Total Insurance Payments	-\$1,428.88
Total Adjustments	-\$446.12
Total Patient Payments	\$0.00
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Total Patient Responsibility	\$200.00
Total Payment Plan Balance	\$0.00
Payment Plan Amount Due	\$0.00

**Total Amount Due Upon Receipt \$200.00**

Please pay balance due upon receipt. Contact Customer Service at 206-598-1950 to update your account or to set up a payment plan. Visit our website at [www.uwmedicine.org/billing](http://www.uwmedicine.org/billing) for more information.

**For your convenience, Harborview Medical Center offers online bill pay at:  
[www.payhmc.com](http://www.payhmc.com)**

If your insurance coverage has recently changed or if you have coverage not listed with your accounts in the Detailed Account Activity section, your account must be updated. To update your account, complete and mail in the CHANGE OF INSURANCE section on the next page or contact Customer Service for assistance.

If you need help paying your bill, whether or not you have insurance, you may qualify for financial assistance. For more information, see our website at [www.uwmedicine.org/financialassistance](http://www.uwmedicine.org/financialassistance) or call 206-598-1950.

Si necesita ayuda para pagar su factura, tenga o no tenga seguro, usted puede ser considerado para recibir asistencia financiera. Para obtener más información, visite nuestro sitio web en [www.uwmedicine.org/financialassistance](http://www.uwmedicine.org/financialassistance) o llame al 206-598-1950.

**RETAIN THIS PORTION OF YOUR STATEMENT FOR TAX PURPOSES**



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**For your convenience, pay your bill  
ONLINE AT [WWW.PAYHMC.COM](http://WWW.PAYHMC.COM)**

**OR**

**MAKE CHECKS PAYABLE TO:**

Harborview Medical Center  
PO Box 34570  
Seattle WA 98124-1570

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

<input type="checkbox"/> MasterCard	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS
CARD NUMBER			
NAME ON CARD			EXP DATE
ADDRESS OF CARD HOLDER			
SIGNATURE			
GUARANTOR NUMBER	STATEMENT DATE		
0123456	11/06/2018		
AMOUNT DUE	AMOUNT ENCLOSED		
\$200.00			

Check box if your insurance or address has recently changed and complete the form on the back of this stub.