

UNITED STATES BANKRUPTCY COURT		PROOF OF CLAIM
Name of Debtor: Hutcheson Medical Center	Case Number: 14-42863-pwb	RECEIVED SEP 19 2016 BMC GROUP
NOTE: Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing. You may file a request for payment of an administrative expense according to 11 U.S.C. § 503.		
Name of Creditor (the person or other entity to whom the debtor owes money or property): The Plastic Surgery Group PC		COURT USE ONLY
Name and address where notices should be sent: 979 East Third St Ste C920 Chattanooga TN 37403 Telephone number: 423-756-7134 email: bettye.chastain@the-psg.org		<input type="checkbox"/> Check this box if this claim amends a previously filed claim. Court Claim Number: _____ (If known) Filed on: _____
Name and address where payment should be sent (if different from above): Telephone number: _____ email: bettye.chastain@the-psg.org		<input checked="" type="checkbox"/> Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.
1. Amount of Claim as of Date Case Filed: \$ 29,953.00 If all or part of the claim is secured, complete item 4. If all or part of the claim is entitled to priority, complete item 5. <input checked="" type="checkbox"/> Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.		
2. Basis for Claim: Services provided - medical (See instruction #2)		
3. Last four digits of any number by which creditor identifies debtor: multi accts	3a. Debtor may have scheduled account as: _____ (See instruction #3a)	3b. Uniform Claim Identifier (optional): _____ (See instruction #3b)
4. Secured Claim (See instruction #4) Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.		
Nature of property or right of setoff: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other Describe: Value of Property: \$ _____ Annual Interest Rate _____ % <input type="checkbox"/> Fixed or <input type="checkbox"/> Variable (when case was filed)	Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any: \$ _____ Basis for perfection: _____ Amount of Secured Claim: \$ _____ Amount Unsecured: \$ _____	
5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507 (a). If any part of the claim falls into one of the following categories, check the box specifying the priority and state the amount.		
<input type="checkbox"/> Domestic support obligations under 11 U.S.C. § 507 (a)(1)(A) or (a)(1)(B). <input type="checkbox"/> Up to \$2,775* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use – 11 U.S.C. § 507 (a)(7).	<input type="checkbox"/> Wages, salaries, or commissions (up to \$12,475*) earned within 180 days before the case was filed or the debtor's business ceased, whichever is earlier – 11 U.S.C. § 507 (a)(4). <input type="checkbox"/> Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).	<input type="checkbox"/> Contributions to an employee benefit plan – 11 U.S.C. § 507 (a)(5). <input type="checkbox"/> Other -- Specify applicable paragraph of 11 U.S.C. § 507 (a)(____).
		Amount entitled to priority: \$ _____
*Amounts are subject to adjustment on 4/01/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.		
6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)		

Hutcheson Med POC
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7. Documents: Attached are redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and redacted copies of documents providing evidence of perfection of a security interest are attached. If the claim is secured by the debtor's principal residence, the Mortgage Proof of Claim Attachment is being filed with this claim. (See instruction #7, and the definition of "redacted".)

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain:

8. Signature: (See instruction #8)

Check the appropriate box.

- I am the creditor. I am the creditor's authorized agent. I am the trustee, or the debtor, or their authorized agent. I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)
(See Bankruptcy Rule 3004.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Betty Chastain
 Title: Business Office Coordinator
 Company: The Plastic Surgery Group
 Address and telephone number (if different from notice address above): _____

Betty Chastain SEP 13 2016
 (Signature) (Date)

Telephone number: _____ email: _____

Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, exceptions to these general rules may apply.

Items to be completed in Proof of Claim form

Court, Name of Debtor, and Case Number:
 Fill in the federal judicial district in which the bankruptcy case was filed (for example, Central District of California), the debtor's full name, and the case number. If the creditor received a notice of the case from the bankruptcy court, all of this information is at the top of the notice.

Creditor's Name and Address:
 Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:
 State the total amount owed to the creditor on the date of the bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:
 State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on delivering health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if an interested party objects to the claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor:
 State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor.

3a. Debtor May Have Scheduled Account As:
 Report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

3b. Uniform Claim Identifier:
 If you use a uniform claim identifier, you may report it here. A uniform claim identifier is an optional 24-character identifier that certain large creditors use to facilitate electronic payment in chapter 13 cases.

4. Secured Claim:
 Check whether the claim is fully or partially secured. Skip this section if the

claim is entirely unsecured. (See Definitions.) If the claim is secured, check the box for the nature and value of property that secures the claim, attach copies of lien documentation, and state, as of the date of the bankruptcy filing, the annual interest rate (and whether it is fixed or variable), and the amount past due on the claim.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507 (a).
 If any portion of the claim falls into any category shown, check the appropriate box(es) and state the amount entitled to priority. (See Definitions.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Credits:
 An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

7. Documents:
 Attach redacted copies of any documents that show the debt exists and a lien secures the debt. You must also attach copies of documents that evidence perfection of any security interest and documents required by FRBP 3001(c) for claims based on an open-end or revolving consumer credit agreement or secured by a security interest in the debtor's principal residence. You may also attach a summary in addition to the documents themselves. FRBP 3001(c) and (d). If the claim is based on delivering health care goods or services, limit disclosing confidential health care information. Do not send original documents, as attachments may be destroyed after scanning.

8. Date and Signature:
 The individual completing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. If you sign this form, you declare under penalty of perjury that the information provided is true and correct to the best of your knowledge, information, and reasonable belief. Your signature is also a certification that the claim meets the requirements of FRBP 9011(b). Whether the claim is filed electronically or in person, if your name is on the signature line, you are responsible for the declaration. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. If the claim is filed by an authorized agent, provide both the name of the individual filing the claim and the name of the agent. If the authorized agent is a servicer, identify the corporate servicer as the company. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS**INFORMATION****Debtor**

A debtor is the person, corporation, or other entity that has filed a bankruptcy case.

Creditor

A creditor is a person, corporation, or other entity to whom debtor owes a debt that was incurred before the date of the bankruptcy filing. See 11 U.S.C. §101 (10).

Claim

A claim is the creditor's right to receive payment for a debt owed by the debtor on the date of the bankruptcy filing. See 11 U.S.C. §101 (5). A claim may be secured or unsecured.

Proof of Claim

A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the debtor on the date of the bankruptcy filing. The creditor must file the form with the clerk of the same bankruptcy court in which the bankruptcy case was filed.

Secured Claim Under 11 U.S.C. § 506 (a)

A secured claim is one backed by a lien on property of the debtor. The claim is secured so long as the creditor has the right to be paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien.

A claim also may be secured if the creditor owes the debtor money (has a right to setoff).

Unsecured Claim

An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. § 507 (a)

Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted

A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor must show only the last four digits of any social-security, individual's tax-identification, or financial-account number, only the initials of a minor's name, and only the year of any person's date of birth. If the claim is based on the delivery of health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information.

Evidence of Perfection

Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

Acknowledgment of Filing of Claim

To receive acknowledgment of your filing, you may either enclose a stamped self-addressed envelope and a copy of this proof of claim or you may access the court's PACER system (www.pacer.psc.uscourts.gov) for a small fee to view your filed proof of claim.

Offers to Purchase a Claim

Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court or the debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 *et seq.*), and any applicable orders of the bankruptcy court.

CHATTANOOGA, TN 37403-2136
423 756 7134

Patient Name: [REDACTED] | Resp Party: [REDACTED]
Patient #: [REDACTED] | Bill To #: [REDACTED]
DOB: [REDACTED]
Death Date: 00/00/0000 | Dr #: 18 JIMMY L WALDROP
Age: [REDACTED] | RDr #: [REDACTED]
SSN: [REDACTED] | Patient Type: 5 CONTRACTED
Bill Cycle: 1 A-L
Credit Status: 0

Date Registered: 12/02/2014
Patient E-mail: JBSCAT@FARMERSTEL.COM
Responsible Party E-mail: JBSCAT@FARMERSTEL.COM

Balances
0 - 30: .00
31 - 60: .00
61 - 90: .00
91 - 120: .00
121 - 150: .00
151+ : 8,700.00

Total Balance: 8,700.00
- Pending: .00
= Patient Balance: 8,700.00

Responsible Party Address:
[REDACTED]
H/Ph #: [REDACTED] M/Ph #: [REDACTED]
W/Ph #: 000-0000
Patient Address:
[REDACTED]
H/Ph #: [REDACTED] M/Ph #: [REDACTED]
W/Ph #: 000-0000

Budget Due: .00
Non-budget Due: 8,700.00
Total Due: 8,700.00
Budget Balance: .00
Budget Payment: .00

Last Transactions:
Charge: 07/20/2015 .00
Personal: 08/24/2016 156.28
Insurance: 02/16/2016 .00

Billing History: 08/15/2016 07/15/2016
04/15/2016 03/15/2016

Location: 1 PSG DOWNTOWN
Diagnosis: V10.3 HISTORY/NEOPLAS
V45.71 ACQUIRED ABSENC

Current Coverages

Cov# Insurance Company Insurance Plan Subscriber
1 [REDACTED] PA [REDACTED]
Subscriber ID: [REDACTED]
Patient ID: [REDACTED]

Debit mode details

Patient#/Name: [REDACTED]
Post Date Debit# Batch#/User Dr# Name Loc# Name Orig Pend Total
12/08/2014 988380U 4/blackj 18 J WALDROP 1 PSG DOWNT 218.00 218.00
Cov# Claim# Ins Co# Name Filed Refiled BA PB Status
1 9883801 280 INSURANCE COMPANY MI 12/09/2014 01/05/2015 Y N Paid
Post Date Receipt# Cov# Transaction Type Amount Applied
12/12/2014 1628495U 1 2000020 NO COVERAGE .00 .00
02/16/2016 1733787U 1 2000280 Claim Released INSURANCE COMPANY MI .00 .00
07/12/2016 1763387U 1000005 CREDIT/DEBIT CARD PAYMENT 200.00 200.00-
08/24/2016 1771714U 1000005 CREDIT/DEBIT CARD PAYMENT 156.28 18.00-
Paid Write-off
Primary: .00 .00 Personal Paid: 218.00 Total Balance: .00
Secondary: .00 .00 Other Paid: .00 Pending: .00
Tertiary: .00 .00 Pat Paid On Form: .00 Patient Balance: .00
Ins Total: .00 .00

Patient#/Name: 90148754 CATHY HULSEY

CHATTANOOGA, TN 37403-2136
423 756 7134

Patient Name: [REDACTED] | Resp Party: [REDACTED]
Patient #: [REDACTED] | Bill To #: [REDACTED]
DOB: [REDACTED]
Death Date: 00/00/0000 | Dr #: 18 JIMMY L WALDROP
Age: [REDACTED] | RDr #: [REDACTED]
SSN: [REDACTED] | Patient Type: 5 CONTRACTED
| Bill Cycle: 1 A-L
| Credit Status: 0
Date Registered: 12/02/2014

Patient E-mail: JBSCAT@FARMERSTEL.COM
Responsible Party E-mail: JBSCAT@FARMERSTEL.COM

Balances
0 - 30: .00
31 - 60: .00
61 - 90: .00
91 - 120: .00
121 - 150: .00
151+ : 8,700.00

Total Balance: 8,700.00
- Pending: .00
= Patient Balance: 8,700.00

Budget Due: .00
Non-budget Due: 8,700.00
Total Due: 8,700.00
Budget Balance: .00
Budget Payment: .00

Billing History: 08/15/2016 07/15/2016
04/15/2016 03/15/2016

Responsible Party Address:
[REDACTED]
[REDACTED]
H/Ph #: [REDACTED] M/Ph #: [REDACTED]
W/Ph #: 000-0000
Patient Address:
[REDACTED]
[REDACTED]
H/Ph #: [REDACTED] M/Ph #: [REDACTED]
W/Ph #: 000-0000

Last Transactions:
Charge: 07/20/2015 .00
Personal: 08/24/2016 156.28
Insurance: 02/16/2016 .00

Location: 1 PSG DOWNTOWN
Diagnosis: V10.3 HISTORY/NEOPLAS
V45.71 ACQUIRED ABSENC

Current Coverages

Cov# Insurance Company Insurance Plan Subscriber
1 [REDACTED] PA [REDACTED]
Subscriber ID: [REDACTED]
Patient ID:

Debit mode details

Patient#/Name: [REDACTED]
Post Date Debit# Batch#/User Dr# Name Loc# Name Orig Pend Total
12/08/2014 988380U 4/blackj 18 J WALDROP 1 PSG DOWNT 218.00 218.00
Cov# Claim# Ins Co# Name Filed Refiled BA PB Status
1 9883801 280 INSURANCE COMPANY MI 12/09/2014 01/05/2015 Y N Paid
Post Date Receipt# Cov# Transaction Type Amount Applied
12/12/2014 1628495U 1 2000020 NO COVERAGE .00 .00
02/16/2016 1733787U 1 2000280 Claim Released INSURANCE COMPANY MI .00 .00
07/12/2016 1763387U 1000005 CREDIT/DEBIT CARD PAYMENT 200.00 200.00-
08/24/2016 1771714U 1000005 CREDIT/DEBIT CARD PAYMENT 156.28 18.00-
Paid Write-off
Primary: .00 .00 Personal Paid: 218.00 Total Balance: .00
Secondary: .00 .00 Other Paid: .00 Pending: .00
Tertiary: .00 .00 Pat Paid On Form: .00 Patient Balance: .00
Ins Total: .00 .00

Patient#/Name: 90148754 CATHY HULSEY

CHATTANOOGA, TN 37403-2136
423 756 7134

Patient Name: [REDACTED] | Resp Party: [REDACTED]
 Patient #: [REDACTED] | Bill To #: [REDACTED]
 DOB: [REDACTED]
 Death Date: 00/00/0000 | Dr #: 18 JIMMY L WALDROP
 Age: [REDACTED] Sex: [REDACTED] | RDr #: [REDACTED]
 SSN: [REDACTED] | Patient Type: [REDACTED]
 | Bill Cycle: 1 A-L
 | Credit Status: 0

Date Registered: 04/17/2014

Patient E-mail: JSHULLAN21594@GMAIL.COM
 Responsible Party E-mail: JSHULLAN21594@GMAIL.COM

Balances
 0 - 30: .00
 31 - 60: .00
 61 - 90: .00
 91 - 120: .00
 121 - 150: .00
 151+ : .00

 Total Balance: .00
 - Pending: .00
 = Patient Balance: .00

Responsible Party Address:
 [REDACTED]
 [REDACTED] M/Ph #: [REDACTED]

 Patient Address:
 [REDACTED]
 [REDACTED] M/Ph #: [REDACTED]

Budget Due: .00
 Non-budget Due: .00
 Total Due: .00
 Budget Balance: .00
 Budget Payment: .00

Last Transactions:
 Charge: 05/08/2015 138.00
 Personal: 05/08/2015 40.00
 Insurance: 02/17/2016 .00

Location: 50 THE PSG EAST
 Diagnosis: V10.3 HISTORY/NEOPLAS
 V45.71 ACQUIRED ABSENC

Billing History: 04/15/2016 03/15/2016
 00/00/0000 00/00/0000

Current Coverages

Cov#	Insurance Company	Insurance Plan	Subscriber
1	[REDACTED]	[REDACTED] N	[REDACTED]
	Subscriber ID: [REDACTED]	802	
	Patient ID: [REDACTED]		
3	8000 COPAY AMOUNT		[REDACTED]
	Subscriber ID: copay \$40		
	Patient ID: [REDACTED]		

Debit mode details

Patient#/Name: [REDACTED]

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
05/06/2014	967092U	9/halest	18 J WALDROP	10 MEM OP	13,122.00	13,122.00
Cov#	Claim#	Ins Co# Name	Filed	Refiled	BA PB Status	
1	9670921	20 GREAT WEST	05/13/2014		Y N Paid	
Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied	
09/02/2014	1610537U	1	2000020 PAYMENT MCA ADM	3,153.77	3,153.77-	
09/02/2014	1610538U	1	4000020 WRITE-OFF GREAT WEST	9,968.23	9,968.23-	
Paid		Write-off				
Primary:	3,153.77	9,968.23	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	3,153.77	9,968.23				

CHATTANOOGA, TN 37403-2136
423 756 7134

Patient#/Name: [REDACTED]

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
09/26/2014	981599U	9/halest	18 J WALDROP	19 PLAZA CEN	11,376.00	11,376.00
Cov#	Claim#	Ins Co# Name	Filed	Refiled	BA PB Status	
1	9815991	20 GREAT WEST	09/30/2014		Y N Paid	
3	9815993	8000 COPAY AMOUNT	09/30/2014		N N Waiting COB	
Post Date	Receipt#	Cov#	Transaction Type		Amount	Applied
07/15/2015	1682652U	1	2000020 PAYMENT NCA ADM		895.54	895.54-
07/15/2015	1682653U	1	4000020 WRITE-OFF GREAT WEST		5,632.46	5,632.46-
07/27/2016	1766729U		3000015 TURNED TO COLLECTION AGENCY		20,052.00	4,848.00-
	Paid	Write-off				
Primary:	895.54	5,632.46	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	4,848.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	895.54	5,632.46				

Patient#/Name: [REDACTED]

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
01/12/2015	991920U	9/halest	18 J WALDROP	19 PLAZA CEN	15,106.00	15,106.00
Cov#	Claim#	Ins Co# Name	Filed	Refiled	BA PB Status	
1	9919201	20 GREAT WEST	01/14/2015		Y N Paid	
3	9919203	8000 COPAY AMOUNT	02/22/2016		N N Waiting COB	
Post Date	Receipt#	Cov#	Transaction Type		Amount	Applied
02/17/2016	1734361U	1	2000020 Claim Released GREAT WEST		.00	.00
07/27/2016	1766729U		3000015 TURNED TO COLLECTION AGENCY		20,052.00	15,106.00-
	Paid	Write-off				
Primary:	.00	.00	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	15,106.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	.00	.00				

CHATTANOOGA, TN 37403-2136
423 756 7134

Patient Name: [REDACTED]
Patient #: [REDACTED]
DOB: [REDACTED]
Death Date: 00/00/0000
Age: [REDACTED] Sex: [REDACTED]
SSN: [REDACTED]

Resp Party: [REDACTED]
Bill To #: [REDACTED]
Dr #: 18 JIMMY L WALDROP
RDr #: [REDACTED]
Patient Type: [REDACTED]
Bill Cycle: 1 A-L
Credit Status: 0

Date Registered: 04/17/2014

Patient E-mail: JSHULLAN21594@GMAIL.COM
Responsible Party E-mail: JSHULLAN21594@GMAIL.COM

Balances
0 - 30: .00
31 - 60: .00
61 - 90: .00
91 - 120: .00
121 - 150: .00
151+ : .00

Total Balance: .00
- Pending: .00
= Patient Balance: .00

Budget Due: .00
Non-budget Due: .00
Total Due: .00
Budget Balance: .00
Budget Payment: .00

Billing History: 04/15/2016 03/15/2016
00/00/0000 00/00/0000

Responsible Party Address:
[REDACTED]
[REDACTED]
[REDACTED] M/Ph #: [REDACTED]

Patient Address:
[REDACTED]
[REDACTED]
[REDACTED] M/Ph #: [REDACTED]

Last Transactions:
Charge: 05/08/2015 138.00
Personal: 05/08/2015 40.00
Insurance: 02/17/2016 .00

Location: 50 THE PSG EAST
Diagnosis: V10.3 HISTORY/NEOPLAS
V45.71 ACQUIRED ABSENC

Current Coverages

Cov#	Insurance Company	Insurance Plan	Subscriber
1	[REDACTED]	[REDACTED]	[REDACTED]
	Subscriber ID: [REDACTED]	802	
	Patient ID: [REDACTED]		
3	8000 COPAY AMOUNT		[REDACTED]
	Subscriber ID: copay \$40		
	Patient ID: [REDACTED]		

Debit mode details

Patient#/Name: [REDACTED]
Post Date Debit# Batch#/User Dr# Name Loc# Name Orig Pend Total
05/06/2014 967092U 9/halest 18 J WALDROP 10 MEM OP 13,122.00 13,122.00
Cov# Claim# Ins Co# Name Filed Refiled BA PB Status
1 9670921 20 GREAT WEST 05/13/2014 Y N Paid
Post Date Receipt# Cov# Transaction Type Amount Applied
09/02/2014 1610537U 1 2000020 PAYMENT MCA ADM 3,153.77 3,153.77-
09/02/2014 1610538U 1 4000020 WRITE-OFF GREAT WEST 9,968.23 9,968.23-
Paid Write-off
Primary: 3,153.77 9,968.23 Personal Paid: .00 Total Balance: .00
Secondary: .00 .00 Other Paid: .00 Pending: .00
Tertiary: .00 .00 Pat Paid On Form: .00 Patient Balance: .00
Ins Total: 3,153.77 9,968.23

CHATTANOOGA, TN 37403-2136
 423 756 7134

Patient#/Name: ██████████ ██████████ ██████████

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
09/26/2014	981599U	9/halest	18 J WALDROP	19 PLAZA CEN	11,376.00	11,376.00
Cov#	Claim#	Ins Co# Name	Filed	Refiled	BA PB Status	
1	9815991	20 GREAT WEST	09/30/2014		Y N Paid	
3	9815993	8000 COPAY AMOUNT	09/30/2014		N N Waiting COB	
Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied	
07/15/2015	1682652U	1	2000020 PAYMENT NCA ADM	895.54	895.54-	
07/15/2015	1682653U	1	4000020 WRITE-OFF GREAT WEST	5,632.46	5,632.46-	
07/27/2016	1766729U	3000015	TURNED TO COLLECTION AGENCY	20,052.00	4,848.00-	
		Paid	Write-off			
Primary:	895.54	5,632.46	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	4,848.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	895.54	5,632.46				

Patient#/Name: ██████████ ██████████ ██████████

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
01/12/2015	991920U	9/halest	18 J WALDROP	19 PLAZA CEN	15,106.00	15,106.00
Cov#	Claim#	Ins Co# Name	Filed	Refiled	BA PB Status	
1	9919201	20 GREAT WEST	01/14/2015		Y N Paid	
3	9919203	8000 COPAY AMOUNT	02/22/2016		N N Waiting COB	
Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied	
02/17/2016	1734361U	1	2000020 Claim Released GREAT WEST	.00	.00	
07/27/2016	1766729U	3000015	TURNED TO COLLECTION AGENCY	20,052.00	15,106.00-	
		Paid	Write-off			
Primary:	.00	.00	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	15,106.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	.00	.00				

CHATTANOOGA, TN 37403-2136
423 756 7134

Patient Name: [REDACTED] | Resp Party: [REDACTED]
 Patient #: [REDACTED] | Bill To #: [REDACTED]
 DOB: [REDACTED]
 Death Date: 00/00/0000 | Dr #: 2 JASON P REHM
 Age: [REDACTED] Sex: [REDACTED] | RDr #:
 SSN: [REDACTED] | Patient Type: 1 SELF PAY
 | Bill Cycle: 1 A-L
 | Credit Status: 2

Date Registered: 06/17/2015

Patient E-mail:
Responsible Party E-mail:

Balances
 0 - 30: .00
 31 - 60: .00
 61 - 90: .00
 91 - 120: .00
 121 - 150: .00
 151+ : 638.00

 Total Balance: 638.00
 - Pending: .00
 = Patient Balance: 638.00

Responsible Party Address:
 [REDACTED]
 H/Ph #: [REDACTED] M/Ph #: [REDACTED]
 W/Ph #: 000-0000
 Patient Address:
 [REDACTED]
 H/Ph #: [REDACTED] #: 000-0000
 W/Ph #: 000-0000

Budget Due: .00
 Non-budget Due: 638.00
 Total Due: 638.00
 Budget Balance: .00
 Budget Payment: .00

Last Transactions:
 Charge: 04/13/2016 .00
 Personal: 08/31/2015 63.21
 Insurance: 05/06/2016 .00
 Location: 1 PSG DOWNTOWN
 Diagnosis: Z41.1 ENCOUNTER FOR COSMETIC

Billing History: 08/15/2016 06/14/2016
 05/13/2016 04/15/2016

Current Coverages

Cov#	Insurance Company	Insurance Plan	Subscriber
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Debit mode details

Patient#/Name:	Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
[REDACTED]	06/18/2015	1007779U	4/blackj	2 J REHM	1 PSG DOWNT	359.00	359.00
		Paid	Write-off				
Primary:		.00	.00	Personal Paid:	.00	Total Balance:	359.00
Secondary:		.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:		.00	.00	Pat Paid On Form:	.00	Patient Balance:	359.00
Ins Total:		.00	.00				

Patient#/Name:	Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
[REDACTED]	06/30/2015	1007794U	4/blackj	2 J REHM	1 PSG DOWNT	279.00	279.00
		Paid	Write-off				
Primary:		.00	.00	Personal Paid:	.00	Total Balance:	279.00
Secondary:		.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:		.00	.00	Pat Paid On Form:	.00	Patient Balance:	279.00
Ins Total:		.00	.00				

CHATTANOOGA, TN 37403-2136
423 756 7134

Patient Name: [REDACTED]
Patient #: [REDACTED]
DOB: [REDACTED]
Death Date: 00/00/0000
Age: Sex: [REDACTED]
SSN: [REDACTED]3

Resp Party: [REDACTED]
Bill To #: [REDACTED]
Dr #: 2 JASON P REHM
RDr #:
Patient Type: 1 SELF PAY
Bill Cycle: 1 A-L
Credit Status: 2

Date Registered: 06/17/2015

Patient E-mail:
Responsible Party E-mail:

Balances
0 - 30: .00
31 - 60: .00
61 - 90: .00
91 - 120: .00
121 - 150: .00
151+ : 638.00

Total Balance: 638.00
- Pending: .00
= Patient Balance: 638.00

Responsible Party Address:
[REDACTED]
H/Ph #: [REDACTED] M/Ph #: [REDACTED]
W/Ph #: 000-0000
Patient Address:
[REDACTED]
H/Ph #: [REDACTED] #: 000-0000
W/Ph #: 000-0000

Budget Due: .00
Non-budget Due: 638.00
Total Due: 638.00
Budget Balance: .00
Budget Payment: .00

Last Transactions:
Charge: 04/13/2016 .00
Personal: 08/31/2015 63.21
Insurance: 05/06/2016 .00

Location: 1 PSG DOWNTOWN
Diagnosis: Z41.1 ENCOUNTER FOR COSMETIC

Billing History: 08/15/2016 06/14/2016
05/13/2016 04/15/2016

Current Coverages

Cov# Insurance Company Insurance Plan Subscriber

Debit mode details

Patient#/Name: [REDACTED]
Post Date Debit# Batch#/User Dr# Name Loc# Name Orig Pend Total
06/18/2015 1007779U 4/blackj 2 J REHM 1 PSG DOWNT 359.00 359.00
Paid Write-off
Primary: .00 .00 Personal Paid: .00 Total Balance: 359.00
Secondary: .00 .00 Other Paid: .00 Pending: .00
Tertiary: .00 .00 Pat Paid On Form: .00 Patient Balance: 359.00
Ins Total: .00 .00

Patient#/Name: [REDACTED]
Post Date Debit# Batch#/User Dr# Name Loc# Name Orig Pend Total
06/30/2015 1007794U 4/blackj 2 J REHM 1 PSG DOWNT 279.00 279.00
Paid Write-off
Primary: .00 .00 Personal Paid: .00 Total Balance: 279.00
Secondary: .00 .00 Other Paid: .00 Pending: .00
Tertiary: .00 .00 Pat Paid On Form: .00 Patient Balance: 279.00
Ins Total: .00 .00
