B10 (Official Form 10) (04/13)		T
UNITED STATES BANKRUPTCY COURT		PROOF OF CLAIM
Hutcheson Medical Center	Case Number:	RECEIVED
NOTE: Do not use this form to make a claim for an administrative expense that arises	14-42863-4wb	SEP 1 9 2016
may file a request for payment of an administrative expense according to Name of Creditor (the person or other entity to whom the debtor owes money or property	11 U.S.C. § 503.	BMC GROUP
The Plastic Jurgery Group PC		COURT USE ONLY
Name and address where notices should be sent:		Court Claim Number:
Telephone with the norga TN 37403 Telephone with the norga TN 37403	•	(If known)
Name and address where payment should be sent (if different from above):	e pop org	Filed on: Check this box if you are aware that
Telephone number: email: better. chastars of	thepsg.org	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: S 39,953.00	-	
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.		
TCheck this box if the claim includes interest or other charges in addition to the princip		statement that itemizes interest or charges.
2. Basis for Claim: Sexuces proided - Me (See instruction #2)	edical	
3. Last four digits of any number by which creditor identifies debtor:	3b. Uniform Claim Identif	ier (optional):
Muti acts (See instruction #3a)	(See instruction #3b)	
4. Secured Claim (See instruction #4)	Amount of arrearage and included in secured claim,	other charges, as of the time case was filed, if any:
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required reducted documents, and provide the requested information.		S
Nature of property or right of setoff: Real Estate Motor Vehicle Other Describe:	Basis for perfection:	
Value of Property: \$	Amount of Secured Claim	: \$
Annual Interest Rate%	Amount Unsecured:	\$
5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507 (a). If any part of the priority and state the amount.	he claim falls into one of the fol	lowing categories, check the box specifying
U.S.C. § 507 (a)(1)(A) or (a)(1)(B). U.S.C. § 507 (a)(1)(A) or (a)(1)(B). U.S.C. § 507 (a)(4). U.S.C. § 507 (a)(4).	as filed or the employee ben	efit plan –
☐ 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).	ntal units - Other Sp applicable par 11 U.S.C. § 5	ragraph of
*Amounts are subject to adjustment on 4/01/16 and every 3 years thereafter with respec	et 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)
	<u> </u>	Hutcheson Med

B10 (Official Form 10) (04/13) 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 reduced 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 "reducted".) 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, T am a guarantor, surety, indorser, or other codebtor. or their authorized agent. (See Bankruptey 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. Chastain Title: Company: Address and telephone number (if different from notice address above)

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.

email:

Creditor's Name and Address:

Telephone number:

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(p).

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.

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

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

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.

INFORMATION

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.

THE PLASTIC SURGERY GROUP PC [CQFMAIN] Inquiry 979 E 3RD ST STE C920 Date 09/13/2016 Time 3:13p CHATTANOOGA, TN 37403-2136 User chastain 423 756 7134 Page 1 Patient Name: | Resp Party: | Bill To #: Patient #: DOB: | Dr #: 18 JIMMY L WALDROP Death Date: 00/00/0000 | RDr #: Age: | Patient Type: 5 CONTRACTED SSN: 1 A-L | Bill Cycle: Date Registered: 12/02/2014 | Credit Status: 0 _____ Patient E-mail: JBSCAT@FARMERSTEL.COM Responsible Party E-mail: JBSCAT@FARMERSTEL.COM Balances Responsible Party Address: 0 - 30: 31 - 60: .00 .00 61 - 90: .00 .00 91 - 120: H/Ph #: M/Ph #: .00 121 - 150: W/Ph #: 000-0000 8,700.00 | Patient Address: 151+ Total Balance: 8,700.00 .00 - Pending: H/Ph #: M/Ph #: 🛊 8,700.00 = Patient Balance: W/Ph #: 000-0000 Last Transactions: .00 Budget Due: Charge: 07/20/2015 .00 Non-budget Due: 8,700.00 Personal: 08/24/2016 156.28 8,700.00 .00 Total Due: Insurance: 02/16/2016 .00 Budget Balance: .00 1 PSG DOWNTOWN Budget Payment: Location: V10.3 HISTORY/NEOPLAS V45.71 'ACQUIRED ABSENC _____ -----| Diagnosis: Billing History: 08/15/2016 07/15/2016 04/15/2016 03/15/2016 Current Coverages Cov# Insurance Company Subscriber Insurance Plan Carried Constitution of the Constitution of th 1 Subscriber ID: Patient ID: ******************* Debit mode details Patient#/Name: Debit# Batch#/User Dr# Name Loc# Name Orig Pend Total Post Date 18 J WALDROP 1 PSG DOWNT 218.00 218.00 988380U 4/blackj 12/08/2014 Filed Refiled BA PB Status Cov# Claim# Ins Co# Name 280 INSURANCE COMPANY MI 12/09/2014 01/05/2015 Y N Paid 9883801 1 Amount Applied Receipt# Cov# Transaction Type Post Date .00 .00 2000020 NO COVERAGE 1628495U 1 12/12/2014 .00 .00 1733787U 1 2000280 Claim Released INSURANCE COMPANY MI 02/16/2016 1000005 CREDIT/DEBIT CARD PAYMENT 200.00 200.00-07/12/2016 1763387U 1000005 CREDIT/DEBIT CARD PAYMENT 156.28 18.00-08/24/2016 1771714U Paid Write-off 218.00 Total Balance: .00 Pending: Personal Paid: Other Paid: .00 .00 Total Balance: .00 Primary: .00 .00 .00 Secondary: .00 .00 .00 Pat Paid On Form: Patient Balance: Tertiary:

Patient#/Name: 90148754 CATHY HULSEY

Ins Total:

.00

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THE PLASTIC SURGERY GROUP PC 979 E 3RD ST STE C920 CHATTANOOGA, TN 37403-2136

423 756 7134

[CQFMAIN] Inquiry 09/13/2016 Date Time 3:13p

User chastain Page 1 _____

Patient Name: Patient #: DOB: 00/00/0000 Death Date: Age: SSN:

| Resp Party: | Bill To #:

18 JIMMY L WALDROP | Dr #: | RDr #: | 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 .00 31 - 60: 61 - 90: .00 .00 91 - 120: .00 121 - 150: 8,700.00 151+

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

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

_____ Billing History: 08/15/2016 07/15/2016 04/15/2016 03/15/2016 | Responsible Party Address:

▶ M/Ph #: H/Ph #: W/Ph #: 000-0000

| Patient Address:

W/Ph #: 000-0000

Last Transactions:

H/Ph #:

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

M/Ph #: 1

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

Current Coverages

Insurance Company Cov# 1

Insurance Plan

Subscriber

Subscriber ID:

Patient ID:

Debit mode details

Patient#/Name:

Orig Pend Total Loc# Name Dr# Name Debit# Batch#/User Post Date 18 J WALDROP 1 PSG DOWNT 218.00 218.00 12/08/2014 9883800 4/blackj Filed Refiled BA PB Status Claim# Ins Co# Name Cov# 280 INSURANCE COMPANY MI 12/09/2014 01/05/2015 Y N Paid 9883801 1 Amount Applied Post Date Receipt# Cov# Transaction Type .00 .00 2000020 NO COVERAGE 1628495U 1 12/12/2014 2000280 Claim Released INSURANCE COMPANY MI .00 .00 02/16/2016 1733787U 1000005 CREDIT/DEBIT CARD PAYMENT 200.00 200.00-07/12/2016 1763387U 18.00-1000005 CREDIT/DEBIT CARD PAYMENT 156.28 08/24/2016 1771714U Paid Write-off .00 Total Balance: 218.00 Personal Paid: .00

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Patient#/Name: 90148754 CATHY HULSEY

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[COFMAIN] THE PLASTIC SURGERY GROUP PC Inquiry 09/13/2016 Date 979 E 3RD ST STE C920 Time 3:11p User chastain CHATTANOOGA, TN 37403-2136 Page 423 756 7134 ________ | Resp Party: Patient Name: | Bill To #: Patient #: DOB: | Dr #: 18 JIMMY L WALDROP 00/00/0000 Death Date: Age: | RDr #: Sex: | Patient Type: SSN: | Bill Cycle: 1 A-L | Credit Status: Ω Date Registered: 04/17/2014 Patient E-mail: JSHULLAN21594@GMAIL.COM Responsible Party E-mail: JSHULLAN21594@GMAIL.COM | Responsible Party Address: Balances 0 - 30: 31 - 60: 61 - 90: .00 .00 .00 M/Ph #: 91 - 120: .00 .00 121 - 150: .00 | Patient Address: 151+ : .00 Total Balance: .00 - Pending: .00 = Patient Balance: | Last Transactions: .00 138.00 Charge: 05/08/2015 Budget Due: .00 05/08/2015 40.00 Personal: Non-budget Due: .00 .00 Insurance: 02/17/2016 Total Due: .00 Budget Balance: 50 THE PSG EAST .00 | Location: Budget Payment: _____| Diagnosis: V10.3 HISTORY/NEOPLAS V45.71 ACOUIRED ABSENC Billing History: 04/15/2016 03/15/2016 00/00/0000 00/00/0000 Current Coverages Insurance Company Insurance Plan Subscriber Cov# N 1 802 Subscriber ID: Patient ID: 8000 COPAY AMOUNT 3 Subscriber ID: copay \$40 Patient ID: ************** Debit mode details Patient#/Name: Dr# Name Loc# Name Orig Pend Total Post Date Debit# Batch#/User 18 J WALDROP 13,122.00 13,122.00 10 MEM OP 05/06/2014 967092U 9/halest Refiled BA PB Status Claim# Ins Co# Name Filed Cov# N Paid 05/13/2014 Y 9670921 20 GREAT WEST 1 Amount Applied Post Date Receipt# Cov# Transaction Type 3,153.77-1610537U 1 2000020 PAYMENT MCA ADM 3,153.77 09/02/2014 9,968.23-9,968.23 4000020 WRITE-OFF GREAT WEST 1610538U 1 09/02/2014 Write-off Paid .00 .00 Total Balance: Personal Paid: .00 9,968.23 3,153.77 Primary: .00 .00 Pending: .00 Other Paid: Secondary: .00 Patient Balance: .00 Pat Paid On Form: .00 Tertiary: .00 9,968.23 Ins Total: 3,153.77

THE PLASTIC SURGERY GROUP PC 979 E 3RD ST STE C920	[CQFMAIN] Inquiry Date 09/13/2016
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Patient#/Name:	Out on Board Board
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Post Date Receipt# Cov# Transaction Type 07/15/2015	895.54 895.54-
07/15/2015	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 To	otal Balance: .00
Secondary: .00 .00 Other Paid: 4,848.00 Pe	ending: .00
Primary: 895.54 5,632.46 Personal Paid: .00 To Secondary: .00 .00 Other Paid: 4,848.00 Personal Paid: .00 Pat Paid On Form: .00 Pat	atient Balance: .00
INS TOTAL. 093.34 3,032.40	
Patient#/Name:	
Post Date Debit# Batch#/User Dr# Name Loc# Name 01/12/2015 991920U 9/halest 18 J WALDROP 19 PLAZA	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 N	BA PB Status
1 9919201 20 GREAT WEST 01/14/2015 3 9919203 8000 COPAY AMOUNT 02/22/2016 Post Date Receipt# Cov# Transaction Type 02/17/2016 1734361U 1 2000020 Claim Released GREAT WEST	Y N Paid
3 9919203 8000 COPAY AMOUNT 02/22/2016	N N Waiting COB
Post Date Receipt# Cov# Transaction Type	Amount Applied .00 .00
07/27/2016 17343610 1 2000020 CTAIM Refeased GREAT WEST 07/27/2016 1766729U 3000015 TURNED TO COLLECTION AGENCY	20,052.00 15,106.00-
Paid Write-off	20,032.00 13,100.00
Primary: .00 .00 Personal Paid: .00 To	otal Balance: .00
Primary: .00 .00 Personal Paid: .00 To Secondary: .00 .00 Other Paid: 15,106.00 Personal Paid: .00 .00 .00 Personal Paid: .00 .00 .00 .00 .00 .00 .	ending: .00
Tertiary: .00 .00 Pat Paid On Form: .00 Pat	atient Balance: .00
Ins Total: .00 .00	

[CQFMAIN] Inquiry THE PLASTIC SURGERY GROUP PC 09/13/2016 Date 979 E 3RD ST STE C920 3:11p Time User chastain CHATTANOOGA, TN 37403-2136 Page 1 423 756 7134 ------| Resp Party: Patient Name: | Bill To #: Patient #: DOB: 18 JIMMY L WALDROP | Dr #: 00/00/0000 Death Date: | RDr #: Sex: Age: | Patient Type: SSN: | Bill Cycle: A-L | Credit Status: 0 Date Registered: 04/17/2014 Patient E-mail: JSHULLAN21594@GMAIL.COM Responsible Party E-mail: JSHULLAN21594@GMAIL.COM | Responsible Party Address: Balances .00 0 - 30: 31 - 60: .00 61 - 90: .00 M/Ph #:■ .00 91 - 120: .00 121 - 150: Patient Address: .00 151 +.00 Total Balance: M/Ph #: 1 .00 - Pending: .00 = Patient Balance: Last Transactions: 138.00 05/08/2015 .00 Charge: Budget Due: 40.00 05/08/2015 Personal: .00 Non-budget Due: .00 Insurance: 02/17/2016 .00 Total Due: .00 Budget Balance: 50 THE PSG EAST | Location: Budget Payment: V10.3 HISTORY/NEOPLAS V45.71 ACQUIRED ABSENC -| Diagnosis: _____ Billing History: 04/15/2016 03/15/2016 00/00/0000 00/00/0000 Current Coverages Subscriber Insurance Plan Cov# Insurance Company 1 802 Subscriber ID: Patient ID: 8000 COPAY AMOUNT 3 Subscriber ID: copay \$40 Patient ID: Debit mode details Patient#/Name: Orig Pend Total Loc# Name Debit# Batch#/User Dr# Name Post Date 13,122.00 13,122.00 18 J WALDROP 10 MEM OP 9/halest 967092U 05/06/2014 PB Status Filed Refiled BA Claim# Ins Co# Name Cov# Y N Paid 05/13/2014 20 GREAT WEST 9670921 1 Applied Receipt# Cov# Transaction Type Amount Post Date 3,153.77-3,153.77 2000020 PAYMENT MCA ADM 1610537U 1 09/02/2014 9,968.23 9,968.23-4000020 WRITE-OFF GREAT WEST 1610538U 1 09/02/2014 Write-off Paid

.00 Total Balance: .00 Personal Paid: 9,968.23 3,153.77 Primary: .00 Pending: .00 Other Paid: .00 .00 Secondary: .00 Patient Balance: Pat Paid On Form: .00 .00 .00 Tertiary: 9,968.23 3,153.77 Ins Total:

THE PLASTIC SURGERY GROUP PC 979 E 3RD ST STE C920

CHATTANOOGA, TN 37403-2136 423 756 7134

[CQFMAIN] Inquiry
Date 09/13/2016
Time 3:11p
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Page 2

Patient#/Name	:					
		ch#/Ilcor	Dr# Name	Log# Name	o Oria Bond	Total
20/26/2014	Denica par	O/holost	10 T WAIDDOD	LOC# Name	e Orig Pend	Total 11,376.00
09/20/2014	3013330	J/Haresc	18 J WALDROP Filed	Dofiled	ZA CEN 11,376.00	11,376.00
COV# CI	aim# ins co# N	anne	Filed 09/30/2	Varitted		
1 981	5991 20 6	KEAT WEST	09/30/20 09/30/20	014	Y N Paid	202
			NT 09/30/2	014		
Post Date					Amount	Applied
	1682652U 1		PAYMENT NCA ADM			895.54-
			WRITE-OFF GREAT WE		5,632.46	
07/27/2016			TURNED TO COLLECTION	ON AGENCY	20,052.00	4,848.00-
		.te-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
Secondary: Tertiary: Ins Total:	895.54 5,	632.46				
Patient#/Name	:					
Patient#/Name Post Date		ch#/User	Dr# Name	Loc# Name	e Orig Pend	Total
Post Date	Debit# Bat					
Post Date 01/12/2015	Debit# Bat 991920U	9/halest	18 J WALDROP	19 PLA	ZA CEN 15,106.00	
Post Date 01/12/2015 Cov# Cl	Debit# Bat 991920U	9/halest	18 J WALDROP	19 PLA	ZA CEN 15,106.00	
Post Date 01/12/2015 Cov# Cl 1 991	Debit# Bat 991920U aim# Ins Co# N 9201 20 G	9/halest Name GREAT WEST	18 J WALDROP Filed 01/14/2	19 PLA: Refiled 015	ZA CEN 15,106.00 BA PB Status Y N Paid	15,106.00
Post Date 01/12/2015 Cov# Cl. 1 991 3 991	Debit# Bat 991920U aim# Ins Co# N 9201 20 0 9203 8000 0	9/halest Jame GREAT WEST COPAY AMOUN	18 J WALDROP Filed 01/14/2 NT 02/22/2	19 PLA Refiled 015 016	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting	15,106.00 COB
Post Date 01/12/2015 Cov# Cl 1 991 3 991 Post Date	Debit# Bat 991920U aim# Ins Co# N 9201 20 0 9203 8000 0 Receipt# Cow	9/halest Jame GREAT WEST COPAY AMOUNT # Transact	18 J WALDROP Filed 01/14/2 NT 02/22/2	19 PLA Refiled 015 016	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting Amount	15,106.00 COB Applied
Post Date 01/12/2015 Cov# Cl 1 991 3 991 Post Date 02/17/2016	Debit# Bat 991920U aim# Ins Co# N 9201 20 0 9203 8000 0 Receipt# Cov 1734361U 1	9/halest Jame GREAT WEST COPAY AMOUNT # Transact 2000020	18 J WALDROP Filed 01/14/2 NT 02/22/2 tion Type Claim Released GRE	19 PLA Refiled 015 016 AT WEST	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting Amount .00	15,106.00 COB Applied .00
Post Date 01/12/2015 Cov# Cl 1 991 3 991 Post Date	Debit# Bat 991920U aim# Ins Co# M 9201 20 6 9203 8000 C Receipt# Cow 1734361U 1 1766729U	9/halest Jame GREAT WEST COPAY AMOUNT # Transact 2000020 3000015	18 J WALDROP Filed 01/14/2 NT 02/22/2	19 PLA Refiled 015 016 AT WEST	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting Amount .00	15,106.00 COB Applied .00
Post Date 01/12/2015 Cov# Cl 1 991 3 991 Post Date 02/17/2016 07/27/2016	Debit# Bat 991920U aim# Ins Co# N 9201 20 6 9203 8000 C Receipt# Cov 1734361U 1 1766729U Paid Wri	9/halest Jame GREAT WEST COPAY AMOUNT # Transact 2000020 3000015 .te-off	18 J WALDROP Filed 01/14/2 NT 02/22/2 tion Type Claim Released GRE TURNED TO COLLECTION	19 PLA Refiled 015 016 AT WEST ON AGENCY	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting Amount .00 20,052.00	15,106.00 COB Applied .00 15,106.00-
Post Date 01/12/2015 Cov# Cl 1 991 3 991 Post Date 02/17/2016 07/27/2016 Primary:	Debit# Bat 991920U aim# Ins Co# N 9201 20 6 9203 8000 C Receipt# Cov 1734361U 1 1766729U Paid Wri	9/halest Jame GREAT WEST COPAY AMOUNT Transact 2000020 3000015 te-off	18 J WALDROP Filed 01/14/2 NT 02/22/2 tion Type Claim Released GRE. TURNED TO COLLECTION	19 PLA Refiled 015 016 AT WEST ON AGENCY	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting Amount .00 20,052.00 Total Balance:	15,106.00 COB Applied .00 15,106.00-
Post Date 01/12/2015 Cov# Cl 1 991 3 991 Post Date 02/17/2016 07/27/2016 Primary: Secondary:	Debit# Bat 991920U aim# Ins Co# M 9201 20 6 9203 8000 C Receipt# Cov 1734361U 1 1766729U Paid Wri .00 .00	9/halest Jame GREAT WEST COPAY AMOUNT # Transact 2000020 3000015 te-off .00 .00	18 J WALDROP Filed 01/14/2 NT 02/22/2 tion Type Claim Released GRE. TURNED TO COLLECTION Personal Paid: Other Paid:	19 PLA Refiled 015 016 AT WEST ON AGENCY .00 15,106.00	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting Amount .00 20,052.00 Total Balance: Pending:	15,106.00 COB Applied .00 15,106.00- .00 .00
Post Date 01/12/2015 Cov# Cl 1 991 3 991 Post Date 02/17/2016 07/27/2016 Primary: Secondary: Tertiary:	Debit# Bat 991920U aim# Ins Co# M 9201 20 0 9203 8000 0 Receipt# Cow 1734361U 1 1766729U Paid Wri .00 .00	9/halest Jame GREAT WEST COPAY AMOUNT # Transact 2000020 3000015 .te-off .00 .00	18 J WALDROP Filed 01/14/2 NT 02/22/2 tion Type Claim Released GRE. TURNED TO COLLECTION	19 PLA Refiled 015 016 AT WEST ON AGENCY .00 15,106.00	ZA CEN 15,106.00 BA PB Status Y N Paid N N Waiting Amount .00 20,052.00 Total Balance: Pending:	15,106.00 COB Applied .00 15,106.00- .00 .00
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THE PLASTIC SURGERY GROUP PC 979 E 3RD ST STE C920

CHATTANOOGA, TN 37403-2136 423 756 7134

[CQFMAIN] Inquiry Date 09/13/2016 Time 3:10p User chastain Page 1

.00 Patient Balance: 279.00

Patient Name: | Resp Party: | Bill To #: Patient #: DOB: Death Date: 00/00/0000 Age: Sex: 🗬 SSN:

| Dr #: 2 JASON P REHM

| RDr #:

| Patient Type: 1 SELF PAY | Bill Cycle: 1 A-L

| Credit Status: 2

Patient E-mail:

Tertiary:

Responsible Party E-mail:

Date Registered: 06/17/2015

Balances		Responsible Party Address:
0 - 30:	.00	
31 - 60:	.00	
61 - 90:	.00	Contraction of the Contraction o
91 - 120:	.00	H/Ph #: M/Ph #:
121 - 150:	.00	W/Ph #: 000-0000
151+ :	638.00	Patient Address:
Total Balance:	638.00	
- Pending:	.00	H/Ph #: 000-0000
= Patient Balance:	638.00	W/Ph #: 000-0000
		Last Transactions:
Budget Due:	.00	Charge: 04/13/2016 .00
Non-budget Due:	638.00	Personal: 08/31/2015 63.21
Total Due:	638.00	Insurance: 05/06/2016 .00
Budget Balance:	.00	1
Budget Payment:	.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

_____ Insurance Plan Cov# Insurance Company Subscriber

Debit mode details

.00

Patient#/Name					_
Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name Orig Pend	Total
06/18/2015	10077790	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	:		E		
Post Date		Batch#/User	Dr# Name	Loc# Name Orig Pend	Total
06/30/2015	1007794U	4/blacki	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
	0.0	0.0	Date Dated On Borns	00 Patient Ralance:	279 00

Ins Total: .00 .00

.00 Pat Paid On Form:

THE PLASTIC SURGERY GROUP PC 979 E 3RD ST STE C920

CHATTANOOGA, TN 37403-2136 423 756 7134

User chastain Page

Time

[CQFMAIN]

Date

Inquiry 09/13/2016

3:10p

1

| Resp Party: Patient Name: | Bill To #: Patient #: DOB: | Dr #: 2 JASON P REHM 00/00/0000

Death Date: Age: Sex: SSN:

Date Registered: 06/17/2015

| RDr #:

| Patient Type: 1 SELF PAY | Bill Cycle: 1 A-L

| Credit Status: 2

Patient E-mail:

Responsible Party E-mail:

Balances		Responsible Party Address:
0 - 30:	.00	
31 - 60:	.00	
61 - 90:	.00	
91 - 120:	.00	H/Ph #: M/Ph #:
121 - 150:	.00	W/Ph #: 000-0000
151+ :	638.00	Patient Address:
Total Balance:	638.00	
- Pending:	.00	H/Ph #: 000-0000
= Patient Balance:	638.00	W/Ph #: 000-0000
		Last Transactions:
Budget Due:	.00	Charge: 04/13/2016 .00

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

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

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

1 PSG DOWNTOWN | Location:

-----| Diagnosis: Z41.1 ENCOUNTER FOR COSMETIC

Current Coverages

Cov# Insurance Company Insurance Plan Subscriber

Debit mode details

Patient#/Name: Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
06/18/2015	10077790		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 Pendi	ng:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00 Patie	nt Balance:	359.00
Ins Total:	.00	.00				

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