

MARC S. LEMCHEN, DMD, PC  
 NEW YORK, NY 10065-8108

PATIENT NAME	PATIENT #	DUE	BALANCE
		590.00	590.00

FOR BILLING INQUIRIES:

PAGE: 1 of 1



JEFFREY EPSTEIN  
 301 EAST 66TH ST APT 11P  
 NEW YORK, NY 10065-6217

**AGING AMOUNTS:**  
 0-30: 0.00  
 31-60: 590.00  
 61-90: 0.00  
 OVER 90: 0.00

32895\*TD50LHFV0000245



DATE	TRANSACTION	PATIENT NAME	AMOUNT
	Previous Balance:		590.00

**PLEASE RETURN THIS PORTION WITH PAYMENT. DO NOT ATTACH CHECK TO STUB.** IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

PATIENT NAME	PAT. #	DUE	PAID
		590.00	

CHECK CARD USING FOR PAYMENT

MASTERCARD   
  DISCOVER   
  DISCOVER   
  VISA   
  VISA   
  AMERICAN EXPRESS   
  AMERICAN EXPRESS

CARD NUMBER \_\_\_\_\_ SIGNATURE CODE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ EXP. DATE \_\_\_\_\_

STATEMENT DATE: 6/1/2015    PAY THIS AMOUNT: \$590.00    ACCT. #: Epstein, Jeffrey

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

32895

PAGE: 1 of 1

SHOW AMOUNT PAID HERE \$

1501558



001125  
0101



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 301 EAST 66TH ST APT 11P  
 NEW YORK, NY 10065-6217



MARC S. LEMCHEN, D.M.D., P.C.  
 NEW YORK, NY 10065-8108

32895\*TD50LHFV0000245



EFTA00317364

SKINMEDICAL RESEARCH AND DIAGNOSTICS, PL  
 DOBBS FERRY, NY 105223520

34572

TEMP RETURN SERVICE REQUESTED



003572  
0101

STATEMENT DATE: 04/29/2015

ACCOUNT NUMBER: [REDACTED]

PATIENT NAME: [REDACTED]

GUARANTOR NAME: [REDACTED]

PAYMENT DUE DATE: 05/20/2015

ADDRESSEE [REDACTED]

301 E. 66TH STREET  
 NEW YORK, NY 10065-6205

PLEASE PROVIDE YOUR UPDATED INFORMATION

VISA   CHECK

CARD/CHECK NUMBER : [REDACTED] AUTHORIZATION CODE [REDACTED]

SIGNATURE : [REDACTED] EXP. DATE : [REDACTED]

PAID AMOUNT\* : \$ [REDACTED] DUE AMOUNT : 280.00

\* For payments through credit card, full balance shall be charged unless an amount is provided. 6537288 (PC1)



REMIT THIS PAYMENT STUB TO [REDACTED]

SKINMEDICAL RESEARCH AND DIAGNOSTICS, PL  
 DOBBS FERRY, NY 10522-0042

Check this box if your address or insurance information has changed. Indicate change(s) on the reverse of this page.

Detach and return this portion with your payment. Please retain bottom portion for your records.

Date of Service	CPT Code	Description	Amount Charged	Pri Ins Payment	Sec Ins Payment	Other Ins Payment	Adjustment	Patient Payment	Patient Balance
04/20/2015	[REDACTED]	Previous Outstanding balance							
		Attending Physician: MELISSA .GILL							
		TISSUE EXAM BY PATHOLOGIST	140.00						
		Primary Ins Rejection							
		Secondary Ins Rejection							
		Other Ins Rejection							
		Total for this Claim	140.00	0.00	0.00	0.00	0.00	0.00	140.00
		Total Amount Due							280.00
Total Amount Due:									\$280.00

PATIENT RESPONSIBILITY/REJECTION(S)

SP - Self pay

NUMBER OF DAYS PAST DUE

0-30	31-60	61-90	91-120	120+
280.00	0.00	0.00	0.00	0.00

CONTACT US:  
 FOR BILLING INQUIRY, PLEASE CALL AT [REDACTED] (8:00 AM - 4:00 PM EST)



Receive Email Statements  
 Register Today!



VISIT:

PATIENT NAME [REDACTED]	PHYSICIAN SERVICES
ACCOUNT NUMBER [REDACTED]	STATEMENT DATE 02/02/15



**eDelivery**  
Coming Soon!



**YOU CAN PAY YOUR BILL ONLINE TODAY! SEE PAYMENT OPTIONS →**

Date	Service Loc.	Proc. Code	Description	Charges	Payments/Adjustments	Balance
01/23/15	OFFICE	JESS TING MD	H2430229 OFFICE VISIT - LEVEL 3	300.00		300.00
<b>TOTAL BALANCE AMOUNT</b>						<b>300.00</b>
<b>TOTAL AMOUNT DUE UPON RECEIPT</b>						<b>300.00</b>

**PAYMENT OPTIONS**

- Pay online at [REDACTED] and register. Once the account has been created, you can pay your bill using our new MyMountSinai Patient Online portal.
- Pay-by-phone [REDACTED] Hours of Operation: 9:00AM TO 5:00PM MON-FRI
- Mail in a check payable to SURGICAL ASSOCIATES with the section below.

Please detach lower portion and send payment in enclosed envelope.

**Mount Sinai Doctors** Faculty Practice  
SURGICAL ASSOCIATES  
MOUNT SINAI MEDICAL CTR  
[REDACTED]  
NEW YORK, NY 10087-0668  
RETURN SERVICE REQUESTED

If paying by Credit Card please fill out below.

<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS
CARD NUMBER	CVV CODE	EXP DATE	
SIGNATURE			CHARGE THIS AMOUNT \$

DUE DATE Upon Receipt	ACCOUNT NUMBER [REDACTED]	PAY THIS AMOUNT <b>\$300.00</b>
Total Amount Paid Here ▶		\$

**▶ PAY ONLINE AT [REDACTED]**

**MAKE CHECK PAYABLE AND REMIT TO:**

301 E 66TH ST  
NEW YORK NY 10065-6205

SURGICAL ASSOCIATES  
MOUNT SINAI MEDICAL CTR  
[REDACTED]  
NEW YORK, NY 10087-0668

Thank you for choosing Palm Beach Pathology for your health care needs.

Statement Date: 12/16/14  
 Responsible Party: [REDACTED]  
 Account Number: [REDACTED]  
 Due Date: Upon Receipt

**REQUEST FOR PAYMENT**

**Summary of Account**

<b>Total Charges</b>	<b>\$ 212.52</b>
Insurance Payments	\$ 0.00
Insurance Adjustments	\$ 0.00
Patient Payments	\$ 0.00
Account Adjustments	\$ 0.00
<b>AMOUNT YOU OWE</b>	<b>\$ 212.52</b>

Your prompt payment is appreciated! Please see the following page for transaction details.

**Payment, Insurance, & Billing Information**



**Pay by credit card online anytime, day or night!**

Pay by credit card via phone [REDACTED]  
 Certified, safe and secure credit card processing.



Visit us at [www.peryourhealth.com](http://www.peryourhealth.com) to update your insurance, address, view your account, or send a message to our billing office.



To contact the billing office, please call [REDACTED] 8:30AM-6:00PM EST Mon-Fri  
 Para asistencia en Español llame al numero de arriba.

**Important Message:**

Your account still has an outstanding balance. Please make payment immediately to avoid further collection activity. Thank you for your prompt attention.

Su cuenta refleja un balance pendiente. Por favor envíe su pago para evitar futuras facturas. Apreciamos su pronta atención.

This statement is for lab tests your physician ordered from Palm Beach Pathology on your behalf. We are not affiliated with your physician. The balance is your responsibility. Please make payment in full using a payment method listed to the left on the statement. If you are unable to pay the full amt, please contact our National Billing Office at [REDACTED] to discuss payment options. **PLEASE DO NOT CALL YOUR PHYSICIAN REGARDING THIS STATEMENT.**

No insurance coverage indicated for the visit shown above.



Palm Beach Pathology  
 [REDACTED]  
 N CHARLESTON, SC 29406

Temp - Return Service Requested

**Pay By Mail** – Please detach and return bottom stub with your check  
 – Include account number on check and correspondence

Account		Patient	
[REDACTED]		[REDACTED]	
Statement Date	Amount Due	Due Date	Amount Paid
12/16/14	\$ 212.52	Upon Receipt	

For your protection: Do not include the credit card information in the mail.

Make CHECK payable and remit to:



**Palm Beach Pathology**  
 [REDACTED]  
 Dallas, TX 75267-1567

001699

PAL\*914\*1314044993C3806

[REDACTED]  
 301 E 66TH ST APT 11B  
 NEW YORK, NY 10065-6217