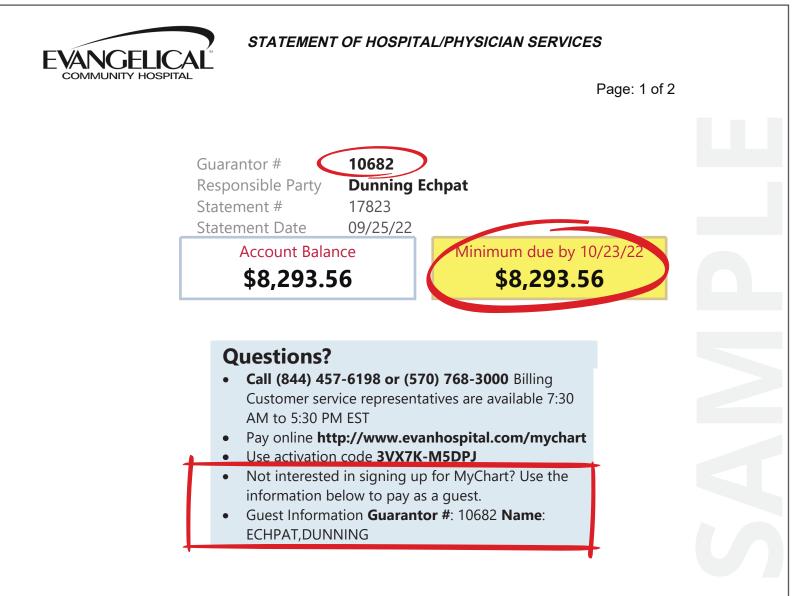
Sample Statement



Federal guidelines prohibit us from disclosing any account information if you are not the patient or authorized representative. In order to discuss such information, the patient or authorized representative must provide consent.

Detach and return bottom portion with payment. Make checks payable to Evangelical Community Hospital and write your guarantor # on the check.

8



My address or insurance information has changed. Changes are written on the back of this form.

| Due Date: 10/23/22 | | Guarantor # 10682 | Statement Date 09/25/22 |
|-----------------------|-----------------|-------------------------------------|----------------------------|
| | Amount Due | Card # | |
| | \$8,293.56 | Exp Date CVV (3-digit code on back) | |
| | Amt Enclosed | | |
| | | Signature | |
| | VISA ¤ | | |

EVANGELICAL COMMUNITY HOSPITAL PO BOX 4885 LANCASTER PA 17604-4885

DUNNING ECHPAT 67 FRONT ST WILBURTON PA 17888

17 00000106828