**Statement of Account**

**To:**

Patient Name

Patient Address

Patient Address

**Date: Statement Number:**

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| --- | --- | --- | --- | --- | --- |
| **Date** | **Reference** | **Description** | **Amount** | **Payment** | **Remaining** |
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**Total**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Payment Due By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have questions about your balance, please contact the office at (360) 876-2434.

Cut Here Please Include This Portion With Your Payment

 **Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sound Health Care Center

Tremont St W STE 200 **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Port Orchard WA, 98366

 **Reference:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Total Paid:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_