



HARVARD

School of Dental Medicine



PATIENT STATEMENT

AMOUNT NOW DUE	STATEMENT DATE	CHART NUMBER
1,206.99	Apr 1, 2026	N/A

ADDRESSEE:

1.1184707.D1.1
 MARTHA TEST
 7 ALTO GRANDE BLVD
 LOS ANGELES CA 90087

MAIL PAYMENT TO:

Harvard Dental Center
 188 Longwood Avenue
 Boston, Ma 02115

Check payable to: Harvard Dental Center

Please check if above address is incorrect and indicate changes

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS RECEIPT WITH YOUR PAYMENT. RETAIN BOTTOM PORTION FOR YOUR RECORDS

DATE	PROC CODE	TOOTH# SURF	PROCEDURE DESCRIPTION	TOTAL AMOUNT	EST. INS. PORTION	EST. PAT. AMOUNT	PAYMENT PLAN AMT.
			Balance prior to: March 19, 2026	1,079.66	0.00	17.00	1,062.66
Patient Name: SCOTT TEST					Chart Number: 50035998		
3/19/2026			Monthly Ortho Fee	\$127.33	\$0.00	\$127.33	\$127.33
3/25/2026	D9986		Missed Appointment	\$0.00	\$0.00	\$0.00	\$0.00
APPOINTMENTS							
April 15, 2026 at 8:00am at the Faculty Group Practice.							

Comments:

Billing@hsdm.harvard.edu or call 617-432-0345
 Pay online: <https://www.hsdm.harvard.edu/patients>

TOTAL DUE	INS DUE	PATIENT DUE	PLAN DUE
1,206.99	0.00	1,206.99	0.00

ABOUT YOUR STATEMENT

- TAX ID: 042103580
- Allow 10 business days for your statement to reflect your payment.
- Refer to past statements for previous detail.
- We accept Mastercard/Visa/American Express by mail, phone or in person (for mail, complete credit card section above)
- Final responsibility for payment rests with the person to whom this statement is addressed.
- This statement is the total account balance. It does not include details of prior financial arrangements.
- Prior balance may include additional account members.
- Allow 8 weeks from the completion of procedure for insurance payment to be received.
- Due to constantly changing insurance regulations, benefits, and deductibles, we are only able to estimate your insurance balance.
- If your insurance company pays more than estimated, your account will be credited.

PATIENT IS RESPONSIBLE FOR BALANCE NOT PAID BY INSURANCE.

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT						GUARANTOR: Martha TEST	Chart # N/A
	CURRENT BALANCE	BAL. OVER 30 DAYS	BAL. OVER 60 DAYS	BAL. OVER 90 DAYS	BAL. OVER 120 DAYS	PAYMENTS RECEIVED AFTER STATEMENT CLOSING DATE ARE NOT REFLECTED ON THIS STATEMENT	
PENDING INSURANCE	0.00	0.00	0.00	0.00	0.00	STATEMENT CLOSING DATE: Apr 1, 2026	
PATIENT RESPONSIBILITY	127.33	627.33	435.33	0.00	17.00		

PLEASE READ THE FRONT OF THIS FORM CAREFULLY BEFORE YOU COMPLETE ANY OF THIS INFORMATION!

CORRECTION OF PERSONAL INFORMATION

NAME		
ADDRESS		
CITY	STATE	ZIP
SOC. SEC NUMBER	PHONE ()	
EMPLOYER'S NAME		
EMPLOYMENT ADDRESS		
CITY	STATE	ZIP
PHONE ()		

INSTRUCTIONS FOR FILING HEALTH INSURANCE CLAIMS

1. If you wish our assistance in filing a claim for your health insurance benefits, please complete the form below and return it to our office. Failure to return the form automatically makes you responsible for payment in full.
 2. If you need another claim filed for a second insurance company, please make a photocopy of the front and back of this statement, then complete one form for each insurance carrier. Return all forms to our office.
 3. Be sure to sign the appropriate authorization(s) for each form submitted.
- Complete all items below and return to our office.

Insurance Company _____ Insurance Co Telephone No. _____

Claim Office Address _____

Policy Number _____ Group Number _____

Name of Insured _____ Home Telephone Number _____

Social Security No. _____ Medicare No. _____ Medicaid No. _____

Employer Of Insured _____ Employer's Telephone No. _____

Employer's Address _____

Relation of Patient to Insured _____ Patient's Date of Birth _____

Was condition related to Employment Auto Accident Date of accident/injury _____

Referring Physician _____

x _____ AUTHORIZED SIGNATURE _____ DATE _____

SAMPLE