Blount Memorial
Hospital

PATIENT RESPONSIBILITY ESTIMATE

Patient Information

Insurance:	Other
Service Date:	9/3/2015

Estimated Charges

Code - Service	Charges	Charges Allowed	Qty	Est. Total
74177 -CT ABD & PELVIS W CONTRST	$4,615.00	$4,615.00	1	$4,615.00
		Total Estimated Charges		**$4,615.00**

Total Estimated Charges	**Estimated Patient Responsibility**
$4,615.00	**$1,020.00**

Benefit	Benefit Category
	CT/MRI Imaging
Payer	Primary
Insurance Adjusted Charges	$4,615.00
Ind Deductible	$1,000.00
Ind Deductible Remaining	$1,000.00
Family Deductible	
Family Deductible Remaining	
Ind Out of Pocket	$2,[illegible]
Ind Out of Pocket Remaining	$2,[illegible].00
Family Out of Pocket	
Family Out of Pocket Remaining	
Co-Pay	[illegible]
Co-Insurance	$0.[illegible]
Estimated Patient Responsibility	[illegible]1,020.00
Total Estimated Responsibility	**$1,0[illegible]**

Patient Deposit :____________________ Date Paid:____________________

The information provided is a hospital estimate and is not a guarantee of final billed charges. Final billed charges may vary from hospital estimates for many reasons, among them are the patient's medical condition, unknown circumstances or complications, final diagnosis and recommended treatment ordered by the physician. Professional fees, such as physician, radiologist, anesthesiologist and pathologist fees are not included in this estimate.

Insurance benefit information (where applicable) is based on information provided by your insurance company as of the date of this estimate. Benefits and eligibility are subject to change and are not a guarantee of payment.

I have read the above information, understand it and accept payment responsibility for final billed charges.

Patient Signature	**Date**	**Hospital Representative Signature**	**Date**

Sample