

BILL: MEDICAL CHART COPIES

Today's Date:

Requesting Party Information

Name/Organization	
Address	
Telephone	
FAX	
Patient Release	A signed release by the patient must be provided.

Patient Information

Patient's Full Name	
Date of Birth	
SS#	

Description	Page Count	Fee
Flat fee for Clerical Searching & Handling		\$ 23.00
First 30 pages @ \$1.02 per page		
31 ST Page thereafter, .78 cents per page		
Provider edits, charged at basic office visit rate		
Subtotal		
Washington Destination Based Sales Tax http://destinationtax.dor.wa.gov		
Certified Mail		\$ 2.70
Return Receipt		\$ 2.20
Postage 0.42 cents per ounce		
Total Due Prior To Mailing		

I decline certified mail and return receipt. The respective costs will be deducted from total due.

Signature _____

Title _____

Date _____

Please submit complete payment and copy of bill to:

ADVANCED PAIN MEDICINE PHYSICIANS, PLLC
PO Box 65017
University Place, 98464-0017

Date Medical Chart Copies Mailed _____