<table>
<thead>
<tr>
<th>1</th>
<th>GUARANTOR ACCOUNT NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>DATE STATEMENT WAS PRINTED</td>
</tr>
<tr>
<td>3</td>
<td>TOTAL GUARANTOR AMOUNT DUE WITH THIS STATEMENT</td>
</tr>
<tr>
<td>4</td>
<td>PAYMENT MAILING ADDRESS</td>
</tr>
<tr>
<td>5</td>
<td>HOW TO CONTACT US WITH QUESTIONS</td>
</tr>
<tr>
<td>6</td>
<td>COMPLETE THIS AREA IF PAYING WITH CREDIT CARD</td>
</tr>
<tr>
<td>7</td>
<td>PATIENT NAME</td>
</tr>
<tr>
<td>8</td>
<td>STATEMENT DUE DATE</td>
</tr>
<tr>
<td>9</td>
<td>ACCOUNT MESSAGES</td>
</tr>
<tr>
<td>10</td>
<td>ACCOUNT NUMBER</td>
</tr>
</tbody>
</table>

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**STATEMENT EXPLANATIONS**

- **GUARANTOR ACCOUNT NUMBER**
- **DATE STATEMENT WAS PRINTED**
- **TOTAL GUARANTOR AMOUNT DUE WITH THIS STATEMENT**
- **PAYMENT MAILING ADDRESS**
- **HOW TO CONTACT US WITH QUESTIONS**
- **COMPLETE THIS AREA IF PAYING WITH CREDIT CARD**
- **PATIENT NAME**
- **STATEMENT DUE DATE**
- **ACCOUNT MESSAGES**
- **ACCOUNT NUMBER**

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**STATEMENT**

Thank you for choosing Swedish Medical Center for your healthcare needs. We hope you had an excellent experience while receiving your care. The charges on this bill are for hospital services only. Physician services are not included. You may receive separate bills from physicians for services such as x-rays, emergency room visits, surgery anesthesia or lab tests. If you have insurance and it is not shown on this bill, please contact us as soon as possible at 1-877-406-0438. Swedish offers financial assistance to those who qualify and an application will be sent to you upon request.

**PATIENT NAME**: ROUNDTHREE, IPONEF

**GUARANTOR NAME**: ROUNDTHREE, IPONEF

**GUARANTOR #:** 4380308

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACCOUNT #</th>
<th>DESCRIPTION</th>
<th>CHARGES</th>
<th>PAYMENTS/ADJUSTMENTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/15/10</td>
<td>2006107</td>
<td>Misc.</td>
<td>$3,187.00</td>
<td>$3,187.00</td>
<td>$3,187.00</td>
</tr>
</tbody>
</table>

**Patient Class**: Inpatient

**Primary Service**: Orthopedics

Message: **BALANCE DUE NOTICE** - We previously sent you a billing statement for your hospital visit. The remaining balance is the amount that is due from you.

---

**REMAINING PAYMENT PLAN BALANCE**: $0.00

**PAYMENT PLAN AMOUNT DUE**: $0.00

**PAYMENT PLAN AMOUNT OVERDUE**: $0.00

**BALANCE NOT ON PAYMENT PLAN**: $3,187.00

**TOTAL PATIENT AMOUNT DUE**: $3,187.00

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**CONTACT INFORMATION**

**SWEDISH MEDICAL CENTER**

CORPORATE BUSINESS OFFICE 747 BROADWAY SEATTLE

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**PAYMENT**

- **STATEMENT DATE**: 12/01/2010
- **BALANCE DUE**: $3,187.00
- **GUARANTOR ACCOUNT #:** 4380308

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**RETURN ENCLOSED TRI FOLD CREASE HERE**