DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	9-10-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000140	[X] Prepare reply for the Director's signature DATE DUE 9-17-07
2. DATE SIGNED BY DIRECTOR Cleared 9/18/07. Letter attached. ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

JOE WILSON
2ND DISTRICT, SOUTH CAROLINA

ASSISTANT REPUBLICAN WHIP

COMMITTEES:
ARMED SERVICES
EDUCATION AND LABOR
FOREIGN AFFAIRS
HOUSE POLICY

Congress of the United States
House of Representatives

COUNTIES:
AIKEN*
ALLENDALE
BARNWELL
BEAUFORT
CALHOUN*
HAMPTON
JASPER
LEXINGTON
ORANGEBURG*
RICHLAND*
(*PARTS OF)

DINO TEPPARA
CHIEF OF STAFF
AND COUNSEL

September 6, 2007

Mr. Robert M. Kerr
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

RECEIVED
SEP 10 2007
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Log: Jacobs
"
dir sign

RE: Mr. Richard Ashford Cook
255-94-5433

Dear Mr. Kerr,

I am writing to you on behalf of the above named constituent who has contacted me regarding his application for Medicaid. Enclosed is a copy of all correspondence for your perusal. Any assistance that you could offer would be most appreciated.

It is an honor to represent the people of the Second Congressional District, and I value your input.

Please respond to the Midlands District Office at 1700 Sunset Blvd., West Columbia, South Carolina 29169; Fax number 803-939-0078. Thank you for your time and concern in this and all other matters.

Yours very truly,

JOE WILSON
Member of Congress

JW/jmc
Enclosure

MIDLANDS OFFICE:
1700 SUNSET BLVD. (US 378), SUITE 1
WEST COLUMBIA, SC 29169
(803) 939-0041
FAX: (803) 939-0078

212 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-4002
(202) 225-2452
FAX: (202) 225-2455
www.joewilson.house.gov

LOWCOUNTRY OFFICE:
903 PORT REPUBLIC STREET
P.O. BOX 1538
BEAUFORT, SC 29901
(843) 521-2530
FAX: (843) 521-2535

TOLL FREE 1-888-381-1442

JOE WILSON
2ND DISTRICT, SOUTH CAROLINA

ASSISTANT MAJORITY WHIP

COMMITTEES:
ARMED SERVICES
INTERNATIONAL RELATIONS
EDUCATION AND THE WORKFORCE
HOUSE POLICY

Congress of the United States
House of Representatives

COUNTIES:
AIKEN*
ALLENDALE
BARNWELL
BEAUFORT
CALHOUN*
HAMPTON
JASPER
LEXINGTON
ORANGEBURG*
RICHLAND*
(*PARTS OF)

ERIC DELL
CHIEF OF STAFF

HHS medicad

Consent for Release of Personal Records by Executive Agencies

Name of Agency: ~~Palmetto South Carolina~~ Lex. Co. Hosp., Rich. Mem., Oncology Ass., ~~Dr. Gordon W. Counts~~

To whom it may concern:

I have sought assistance from Congressman Joe Wilson on a matter that may require the release of information maintained by your agency, and which may be prohibited from dissemination under the Privacy Act of 1974.

I hereby authorize you to release all relevant portions of my records or to discuss information involved in this case with Congressman Wilson or any authorized member of his staff until the matter is resolved.

Richard Ashford Cook — Name of Claimant- (Please Print)

12-09-62 — Date of Birth

P.O. Box 84783 121 Willma Ann Dr. Lexington, S.C. 29073 — Address of Claimant

255-94-5433 — Social Security Number

VA Claim # or OPM # (if applicable)

(803) 665-0652 — Telephone Number-Home

N/A — Telephone Number-Work

Richard A. Cook — Signature of Claimant

August 01, 2007 — Today's Date

Please briefly explain your concern:
(use the back if necessary)

MIDLANDS OFFICE:
1700 SUNSET BLVD. (US 378), SUITE 1
WEST COLUMBIA, SC 29169
MAILING ADDRESS: P.O. BOX 7381
COLUMBIA, SC 29202
(803) 939-0041
FAX: (803) 939-0078

212 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-4002
(202) 225-2452
FAX: (202) 225-2455
E-MAIL: joe.wilson@mail.house.gov
WEBSITE: www.house.gov/joewilson

LOWCOUNTRY OFFICE:
903 PORT REPUBLIC STREET
P.O. BOX 1538
BEAUFORT, SC 29901
(843) 521-2530
FAX: (843) 521-2535

TOLL FREE 1-888-381-1442

South Carolina Department of Health and Human Services
Application for the South Carolina Medicaid Program
This application is developed specifically for Aged, Blind, or Disabled Adults.

Note: *You only need to tell us the Social Security Number and answer the questions about being a US Citizen for the people for whom you want full Medicaid benefits. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.*

- A citizen applying for Medicaid must provide original documents to prove US citizenship and identity
- A non-citizen applying for Medicaid must provide Bureau of Citizenship and Immigration Services (BCIS) documents to support his/her legal entry into the US.
- A non-citizen applying for Emergency Services Only is not required to provide these documents or a Social Security Number.

1. Tell us about yourself.

Date received by DHHS:

Name (First, Middle Initial, Last):			**Social Security Number**: (not required for emergency services)	**Date of Birth:**
Richard Ashford Cook			255-94-5433	12-9-62
Address where you get mail (include apartment number):	**City:**	**State:**	**Zip Code:**	**County:**
P.O. Box 84783	Lexington	SC	29073	Lexington
Home Address (if not the same as your mailing address):	**City:**	**State:**	**Zip Code:**	**Telephone Number:**
121 Wilma Ann Rd	Lexington	SC	29073	(803) 665-4652
Your Full Name at Birth: This helps us verify citizenship	**Your Mother's Full Name at her Birth:**			**County/State where you were born:**
Richard Ashford Cook	Gerda Helga ff Christ			Richland Cty, S.C.

Do you want Medicaid for yourself?	**Sex:**	**Marital Status:**	**Are you currently attending school?**	**Check all that apply:**	**What language do you use most?**
☑ Yes ☐ No	☐ Female ☑ Male	☐ Single ☐ Widowed ☑ Married ☐ Separated ☐ Divorced	☐ Yes ☑ No If yes, what grade? ___	☑ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	☑ English ☐ Sign Language ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Other _____ ☐ Russian

Medicare Number, if applicable:

Race:
☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Cuban
☐ Refugee Entrant ☐ Puerto Rican ☐ Hispanic ☐ Asian American/Oriental ☐ Other

If an Authorized Representative is completing this application, please complete the following:

Name: _____ Phone Number: _____

Address: _____ Relationship: _____

_____

4. Tell us how much income your family has.
Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks.**

Your Income from Employment	Other Parent's/Spouse's Income from Employment *(if living in the home)*
Name of person employed _____	Name of person employed _____
Employer's Name _____	Employer's Name _____
Employer's Address _____	Employer's Address _____
_____	_____ none
Employer's Phone Number (including area code) none _____	Employer's Phone Number (including area code) _____
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Still employed? ☐ Yes ☐ No If no, where did you work last? _____	Still employed? ☐ Yes ☐ No If no, where did you work last? _____
When did you stop working there? _____	When did you stop working there? _____

Is anyone self-employed? ☐ Yes ☐ No If yes, please name Self-Employment Business and/or Partnership _____

You must send copies of all the most recently filed Federal income tax forms with all schedules.

Other Income	Amount	Which family member gets this income?	How often is this income received?
Child Support	$		
Alimony	$		
Social Security Income	$		
Unemployment Benefits	$		
Veterans Benefits	$		
Workers Compensation/Long Term or Short Term Disability	$		
Money from Friends/Relatives	$		
Retirement/Pensions/Annuities	$		
Other Income (*Please Explain*) DISABILITY	$ 1789	Richard Cook - 1296/mo Jeanette Cook - 493/mo	1 x month

3. Tell us about any health or medical insurance covering anyone for whom you are applying. Please send us a copy of the card(s), front and back. Include Medicaid in another state. Even if you already have health insurance, you can still qualify for Medicaid.

Insurance Company	Policy Number	Policyholder's Name	Policyholder's ID	Persons Covered	What type of coverage is this?
none					

IMPORTANT

Check below to tell us what you attached.

- **Sending this information in with the application will help us to process your application faster.**
- **You must read and sign this form on the last page to complete your application.**

☐ Proof Of Income

- ☐ Copies of pay stubs for the **last 4 weeks for any adult person listed**; *or* a letter from employer that shows last 4 weeks of GROSS pay.
- ☐ A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
- ☐ Proof of all other income for the last 4 weeks, including child support.

NOTE: You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.

☐ Proof of Assets/Resources listed in application.

☐ Proof of income/resources for the past 3 months if you have received medical services.

☐ Most recent income tax forms including all schedules, if you are self employed.

☐ Proof of due date from doctor, nurse, or Health Department for each pregnant woman.

☐ Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)

☐ Bureau of Citizenship and Immigration Services (BCIS) documents for each non-citizen applying for full Medicaid. Does not apply to Emergency Services Only.

☐ Original Documents of citizenship and identity for each US citizen applying for Medicaid. (If you have provided this information before, you do not have to provide it again.)

Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Medicaid beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a $25 fee. I want to voluntarily apply for these services: ☐ Yes ☐ No

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).
   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).
   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.
4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.
6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.
7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.
8. I know that I may request a hearing if I believe an error has been made in processing my application.

☑ **I have read the Rights and Responsibilities, or they have been read to me.** *(If possible, both the Applicant and Authorized Representative should sign.)*

Applicant's Signature: Richard A. Cook Date: 07/30/07

Signature of Authorized Representative: _____ Date: _____

5. If your family does not have any source of income, explain in the space below how your household bills are being paid.

6. Does anyone in your family own the following? You must send proof of Assets/Resources with this application.

Asset/Resource	Company name, address, and phone #; Account/Policy number; and/or Description	Who does it belong to?	What is the value?	How much is owed?
Cash on Hand		Richard Cook	$ 1.00	
Checking Account(s)	none		$	
Savings Account(s)	none		$	
Certificate(s) of Deposit	none		$	
Annuities/Trusts/Stocks/ Bonds	none		$	
Safety Deposit Box	none		$	
Home Property (location/description)	rental	Patrica Schwartz Richard Miller	$	$
Other Property (location/description)	none		$	$
Life/Burial insurance	none		$	$
Burial Contracts	none		$	$
Burial Plots	none		$	$
Vehicles (make, model, year)	1987 Dodge Omni		$	$ none
Retirement Account	none		$	$
Other (please be specific)	none		$	$

7. Do you pay someone to take care of your child(ren) under 12 and/or a dependent adult while you work or attend school?
☐ Yes ☑ No _____ Number of children under age 12 and/or dependent adults for whom you pay for care. **You must provide proof of this payment.**

2. Tell us about the people who live with you A Social Security Number is not required if applying for Emergency Services Only.

Name: (First, Middle Initial, Last)	Social Security Number:	Full Name at Birth:	Mother's Full Name at her Birth:
Jeanette E. Cook	247-90-1468	Jeanette Elizabeth Carter	* Mary Agnes Miller Johnnie Helen Carter

Is this person applying for Medicaid?	Check all that apply:	Sex:	Marital Status:	How is this person related to the person on page 1?	Currently attending school?	County/State where you were born:
☐ Yes ☑ No	☐ US Citizen ☑ Disabled ☐ Pregnant ☐ Emergency Services Only	☑ Female ☐ Male	☐ Single ☑ Married ☐ Divorced ☐ Widowed ☐ Separated	☐ Child ☑ Spouse ☐ Other: _____	☐ Yes ☑ No If yes, what grade? _____	Richland County SC Columbia Hosp.

Medicare Number, if applicable:	Date of Birth:	Race:
* 247-90-1468 A	12-25-50	☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other

Name: (First, Middle Initial, Last)	Social Security Number:	Full Name at Birth:	Mother's Full Name at her Birth:
Amy Helen Mary Aldridge	248-43-5911	Amy Helen Mary Aldridge	Jeanette E. Aldridge

Is this person applying for Medicaid?	Check all that apply:	Sex:	Marital Status:	How is this person related to the person on page 1?	Currently attending school?	County/State where you were born:
☐ Yes ☑ No	☑ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	☑ Female ☐ Male	☑ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	☑ Child ☐ Spouse ☐ Other: _____	☐ Yes ☑ No If yes, what grade? _____	Richland Cty, SC.

Medicare Number, if applicable:	Date of Birth:	Race:
	8-13-80	☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other

Name: (First, Middle Initial, Last)	Social Security Number:	Full Name at Birth:	Mother's Full Name at her Birth:

Is this person applying for Medicaid?	Check all that apply:	Sex:	Marital Status:	How is this person related to the person on page 1?	Currently attending school?	County/State where you were born:
☐ Yes ☐ No	☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	☐ Female ☐ Male	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	☐ Child ☐ Spouse ☐ Other: _____	☐ Yes ☐ No If yes, what grade? _____	

Medicare Number, if applicable:	Date of Birth:	Race:
		☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other

3. Retroactive

Do you or anyone who lives with you receive medical services in the past 3 months?

Who_____ Which month(s)?_____

In order for us to determine eligibility for these month(s), you are required to provide proof of income and resources for each month listed.

PSC MedSupply, LLC

LETTER OF SUPPORT

Date: 7/20/07

Name: Mary Amy H. Aldridge
Birthdate: August 13th, 1979
Social Security#: 248-43-5911

To whom it may concern,

I Richard A. Cook am providing shelter, food and basic everyday necessities for Mary Amy H. Aldridge until he/(she) is able to provide for themselves.

Signature: Richard A. Cook Ann Dr.
Address: PO Box 84783 Willmar, MN 56201
Phone: 803-665-4652

SOUTH CAROLINA
ONCOLOGY
ASSOCIATES

166 Stoneridge Dr., Columbia, SC 29210
803-461-3000 FAX 803-461-4917, www.sconcology.net

July 31, 2007

To Whom It May Concern:

Mr. Richard Cook is a patient of Dr. Neal Christiansen being treated for colon cancer that has metastasized to the bladder and the rectum. At the present time he is receiving disability but is in need of assistance for his medical bills. His wife is also on disability and is unable to work. This is an unfortunate situation and any assistance you might give him would be greatly appreciated. If I may answer any other questions you may call me at (803) 461-3198.

Sincerely,

Louise S. Stepp / LMSW, OSW-C

Louise Stepp,LMSW,OSW-C

Southern Surgical group

July 31, 2007

William M. Moore, Jr.
M.D., F.A.C.S.

Terry O. Norton
M.D., F.A.C.S.

Ronald G. Myatich
M.D., F.A.C.S.

Jeffrey S. Libbey
M.D., F.A.C.S.

J. Douglas Reid, III
M.D., F.A.C.S.

Re: Richard Cook
SSN: 255-94-5433
DOB: 12/09/62

To Whom It May Concern:

Mr. Cook has been followed by me since 07/05/06 for what was initially thought to be perforated diverticulitis. He underwent exploratory laparotomy with sigmoid colectomy with end Hartmann's pouch as well as drainage of pelvic abscess on 07/05/06. Unfortunately he was identified to not have diverticulitis but perforated colon carcinoma. He did well from surgery and underwent chemotherapeutic intervention under the direction of Dr. Neal Christiansen at South Carolina Oncology Associates. He underwent port-a-cath placement at an outside institution by another surgeon. He has been followed on a regular basis by me. On 06/22/07, he was re-evaluated and noted to only have a 7-mm left subpleural nodule by CT scan; otherwise his CT scan were clean. He developed port-a-cath erosion as well. It was felt that the patient was a candidate for colostomy takedown and port removal. On 06/26/07, Mr. Cook underwent removal of his right subclavian port-a-cath as well as exploratory laparotomy and colostomy closure with segmental colectomy. At that time, he also had peristomal hernia repair and midline ventral hernia repair. Unfortunately during his surgery, he was identified to have evidence of intraperitoneal metastatic disease. He was identified to have a tumor mass in the left lower quadrant of the abdominal wall which had grown into the bladder as well as a metastatic implant of the rectum. Mr. Cook will likely need additional surgeries in the future as well as additional chemotherapy which will be under the direction of Dr. Christiansen. Should you have any additional questions, please fee free to contact my office at (803) 796-8901.

Sincerely,

Jeffrey S. Libbey, MD

JSL/mdl

GENERAL
LAPAROSCOPIC
VASCULAR
ENDOVASCULAR
AND
THORACIC
SURGERY

Lexington Medical Park 1 • 2728 Sunset Boulevard • Suite 403 • West Columbia, SC 29169
(803) 796-8901 • Billing FAX (803) 796-4217 • Nurse/Clinical FAX (803) 796-9085
www.southernsurgical.com

Back on July 9th, I was at home on a Saturday morning and I woke up in severe pain, my wife had to call E.M.S. 911 to take me to the hospital (Lewis Co.) where they hooked me up to EKG's, X-Rays, all kinds of medical equipment. Dr. Libby was on call and was in charge of my situation, Diverticulitis was the identified problem. But we went into Surgery on July 16th and the following day Dr. Libby came in and said, "Mr. Cook I don't know to tell you but you have Colon Cancer and we aren't sure if it is anywhere else" she said that normally it has and or does ten days to travel through the body. So they also had to do a colostomy w/bag on side. So I set in hospital 7 days with my wife constantly in with me also shocked by the news. But after we got out we had to find help from everywhere we could possible do to get it. My wife is totally disabled and we only get $493.00 a month, we also had to go see the

Cancer doctor. We started doing all this running the day I got out. I had all kind of medicines to get, had bills to pay, and the other life's nessities, food, gas, Colostomy supplies, lotions, ect. When we went to meet Doctor Christiansen w/SCCA he said we would need to locate the mass, so we got appointments to go to Rich. Palm. Memorial. Dr. Clayton found it, we went back to Dr. Christiansen and we got options for biopsy to go at this. So we went back to RPM, to get a Port Cath so we could get ready to start Chemo Therapy. It had to go here (2) because the 1st one was faulty. We were on (5) Liquid Chemo medicines and a pump w/ Chemo medicine for 2 days after the treatment. That did not include 10 oral medicines each had to take. I volunteered for (4) of the (5) Liquid chemo treatments because it was being tried by some others. It did a lot of good but like anything else it has some side effects. We had to run so much, my wife pack holes from the sorgun we also had to have Home Nurse come in 3 Days

to show us how to do the wound packing some on the Clitx Clstmy, temps Bp, ect, We were trying to figure out how are we going to do all this I drove cross country, I had no 401, no ret, no extra money no where. But between the Churches, and some of the organization, (the) family help & we ain't rich w/money, but love, pray, and what help w/got was what we or what my family has help so much as they all could. We feel blessed with love, faith, and a lot of peoples who see and know, how do you go on. Well I applied for medicad SSI Disability, and it was some help. But it was Feb. 99 medicad stoped, SSI stop, and I started my disibility at 1296. We were behind on everything because of [redacted] 8 months all w/re ally had was my wife 493.00 You can guess the stress. If you can't it tough. I had more trips to the Chemo doctors. When and if you pull the my records, you will see all my appointments. I had a lot of back to back appointments.

(4)

I know this letter is scattered but I'm doing everything I'm remembering it. I'm still on alot of medications because I have to. I've never been big on Hosp. ons meds. But I have Colon Cancer, bladder Cancer, and recturn Cancer, high blood pressure, blood clots, sleep apia (Capt. Hosp.). I feared to know anything else. I won't COmph to Omph soda, steal, Ish you don't know, you don't want to. To, I'm not asking for the world and I do want to make sure these folks get what they are s'pose to. But I don't know how what we are working with. I'm stik behind on res, Mas, Dies and other. It would be easier for y'all to pull all my records and see for yourselves. I've run to get what I've got. Tonight I've written this and I have got to get ready for surgery again for a 3rd Bad Part to start the Chemo again. My wife and I need some help w/ this. I'm having severe Barabul pain. All medicines can't ease

it up enough to move around but still uncomfortable. We have more surgery's, Chemo, medicine, CT scan, Cat Scans, X rays. I come asking for this help to give the doctors what are due to them and ask that the medicines I need to help me, comfort me thru these trying time There's alot more to tell and say, also pull the records. Meds are: Benicar HCT 40-12.5 mg. tabs, Coumadin 5mg tabs, Lisinopril HCT2 20/12.5, ATIVAN 1mg Tab, mag-Oxide 400 mg Tab, Oxycodon HCL-APA 10-325 Percocet, Mepergan Forte, NYST-Lido-Benad (CKUD RIK), Duragisics 75mg Morphine This dose not include Chemo liq wds med I will be on 4 of these also, and this is if nothing gets added, we got the colon reconnected, 7 herheias removed, Port removal (on wound), Filters in for clots (blood), bag removed, ~~resection tube~~ Got showing bladder Cancer and restoring Cancer. Also there is some more that is micro scopic. There is more to say but I'm sleepy Thank you for your time Mike

4.

Care, God Bless ☺ Good night

*** REC 2007172 114442 H6A04FE0 CV1C CIPQYAG PQAG (F-CV1) ***

SOCIAL SECURITY ADMINISTRATION

Date: June 21, 2007
Claim Number: 247-90-1468A
247-90-1468DI

JEANETTE E COOK
PO BOX 84783
LEXINGTON SC 29073-0014

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Current Social Security Benefits

Beginning January 2007, the full monthly Social Security benefit before any deductions is.....$ 586.60

We deduct $93.50 for medical insurance premiums each month.

The regular monthly Social Security payment is.....$ 493.00
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the third of each month.

Other Important Information

SENT BY 051.

Type of Social Security Benefit Information

You are entitled to monthly disability benefits.

*** REC 2007172 114458 H6A04FE0 CV1C CIPQYA7 PQA7 (F-HCK) ***

SOCIAL SECURITY ADMINISTRATION

Date: June 21, 2007
Claim Number: 255-94-5433A
255-94-5433DS

RICHARD A COOK
PO BOX 84783
LEXINGTON SC 29073-0014

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Current Social Security Benefits

Beginning December 2006, the full monthly Social Security benefit before any deductions is.....$ 1296.40

We deduct $0.00 for medical insurance premiums each month.

The regular monthly Social Security payment is.....$ 1296.00
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the third of each month.

Other Important Information

SENT BY O51.

Type of Social Security Benefit Information

You are entitled to monthly disability benefits.

G W COUNTS, MD
P O BOX 2629
LEESVILLE, SC 29070
803-532-3857

PRINTED 11:12:42am 10 Aug 2007
BY: PM.AR KARYN
PAGE 1
TAX ID# 57-0445990

RICHARD COOK (16143.4)
P O BOX 700
GASTON, SC 29053

NOTICE, THIS IS LISTED FROM MOST RECENT TO THE OLDEST

Date....	Name...	Code....	Description.....	Link...	Dr..	Fcl	Amount....	Dx
03/27/07	RICHARD	2.2	PAYMENT COMMERCIA	7825.1	1	2	0.00	
03/27/07	RICHARD	71	$27.00 DENIED NOT	7825.1	1	2	0.00	
11/21/06	RICHARD	10.5	MEDICAID WRITEOFF	11559.1	1	5	-9.59	
11/21/06	RICHARD	2.5	PAYMENT MEDICAID	11559.1	1	5	-28.41	
11/21/06	RICHARD	17	$2.00 COPAY	11559.1	1	5	0.00	
11/21/06	RICHARD	16	$30.41 ALLOWED AM	11559.1	1	5	0.00	
11/06/06	RICHARD	1.2	PAYMENT CHECK	12068.1	1	5	-15.00	MED
11/06/06	RICHARD	MEDRC	MEDICAL RECORDS F	12068.1	1	5	15.00	MED
11/03/06	RICHARD	99212	OFFICE OUTPATIENT	11559.1	1	5	40.00	460
07/31/06	RICHARD	99211	OFFICE OUTPATIENT	7825.1	1	2	27.00	401.1
BALANCE							29.00	

DOCTOR..... TAX-ID..... FINANCIAL CLASS
1 GURDON W COUNTS, MD 570445990 2 COMMERCIAL
5 MEDICAID

CHART/11836/JEANETTE 3/22/04 MUST PAY BEFORE BEING SEEN
NEEDS REFILL
SET UP 6 MONTH F/U MAMMOGRAM
GENERAL VISIT
BAD CHECKS!!!!
PT WILL HAVE $50
ALOT OF MOLES TO BE TAKEN OFF
ALOT OF MOLES TO BE TAKEN OFF
WILL PAY $50 ON OLD BALANCE
CHECK SKIN TAGS

PATIENT NO. 16143 JEANETTE E COOK DOB:12/25/1950 SEX:F 247-90-1468
Insurance Company Group Id Number Insured
MEDICARE PART B 247901468A 16143,,,,,,,10928
PATIENT NO. 16143.4RICHARD COOK DOB:12/09/1962 SEX:M 255-94-5433
Insurance Company Group Id Number Insured
CAROLINA CARE PLAN WEO 255945433 16143.4,,,,,,,13150,14061
MEDICAID 5780621822 COOK RICHARD ASHFORD,1070
PATIENT NO. 16143.1DANIEL K LEWIS DOB:07/01/1982 SEX:M 249-53-7490
PATIENT NO. 16143.2AMY ALDRIDGE DOB:08/13/1979 SEX:F 248-43-5911
Insurance Company Group Id Number Insured
MEDICAID 1326759202 ,,,,,,,,
PATIENT NO. 16143.3ASHLEY CHURCH DOB:09/02/1993 SEX:F 247-93-8963
Insurance Company Group Id Number Insured
MEDICAID 2886094902 ,,,,,,,,

YOUR STATEMENT

Our records indicate that you were uninsured at the time of treatment and may be eligible for a 25% discount. To request this discount and verify your eligibility, please call Customer Service at the number indicated.

SUMMARY OF CHARGES

250 PHARMACY GENERAL	340.00
258 PHARMACY IV SOLUTIONS	130.00
270 M/S SUPPLY GENERAL	315.98
272 M/S SUPPLY STERILE SUPPLY	440.58
278 M/S OTHER IMPLANTS	3000.00
300 LABORATORY GENERAL	11.00
305 LAB HEMATOLOGY	124.00
320 RADIOLOGY DIAG GENERAL	678.00
360 OR SVCS GENERAL	3055.00
370 ANESTHESIA GENERAL	720.00
710 RECOVERY ROOM GENERAL	504.00
964 PROF FEES ANESTHETIST CRNA	1125.00
Billed charges to date:	10443.56

INSURANCE INFORMATION

10237-P555

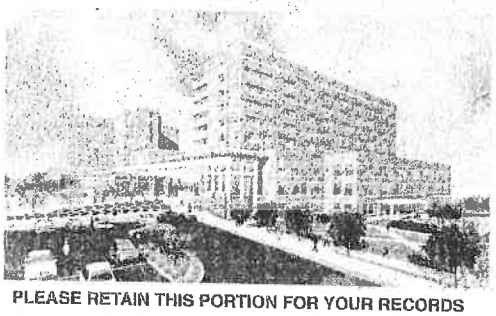
QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2300 OR (877) 835-0975, MONDAY-FRIDAY, 8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	08/08/07
Patient Name:	RICHARD A COOK
Date of Service:	08/02/07
Account Number:	H00029893807
Total Charges:	10443.56
Insurance Payments Received:	0.00
Adjustments to Insurance:	0.00
Patient Payments Received:	0.00

This is your balance: 10443.56



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER

LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

PAGE: 1 of 1

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
08/23/2007	08/08/07	H00029893807

AMOUNT DUE	SHOW AMOUNT PAID HERE
10443.56	$

651741B

0101

ADDRESSEE:

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555*T5H0C9INI000376

0H00029893807000010443566273

Critical Health Systems of SC
PO Box 18089
Raleigh, NC 27619
(888) 280-9533

July 5, 2007

Richard Cook
PO Box 84783

Lexington, SC 29073

Account # L0607251646

Dear Richard Cook,

Critical Health Systems of SC provided your anesthesia or pain services during your recent medical procedure at Lexington Hospital. We were provided with incomplete insurance information. Please complete the enclosed form with correct and updated health insurance information, and mail it back to us in the envelope provided. You may also call us at the number below to supply this information.

If you do not have health insurance at this time, Critical Health Systems of SC does offer the following payment options:

1. Payment in Full (Cash, Check, Visa and MasterCard)
2. Monthly Payment Plan
3. Prompt Pay Discounts

Critical Health Systems of SC appreciates the opportunity to provide your anesthesia or pain services. As providers of this service, we do expect a prompt payment for all services rendered to you. After receiving your first bill, please contact our billing office at 919 873 9533 or toll free 888 280 9533, to speak with a patient service representative.

Thank you for your cooperation.

Para hablar con alguien que hable espanol, por favor llame al 1-888-280-9533 x326.

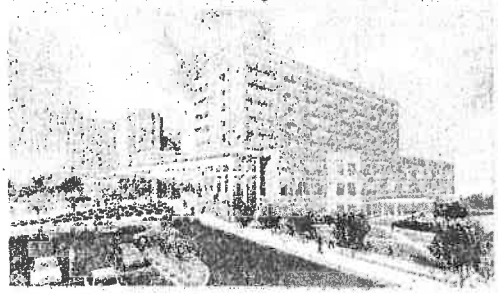
YOUR STATEMENT

Our records indicate the balance is your responsibility and you may be eligible for a 25% discount. To request this discount and verify your eligibility, please call Customer Service at the number indicated.

10237-P555

SUMMARY OF CHARGES

110 PRIVATE ROOM & BOARD	525.00
206 PROGRESSIVE CARE UNIT	6600.00
250 PHARMACY GENERAL	4263.13
255 PHARMACY INCID TO RAD	269.59
258 PHARMACY IV SOLUTIONS	1914.00
259 PHARMACY OTHER	440.75
270 M/S SUPPLY GENERAL	3338.36
272 M/S SUPPLY STERILE SUPPLY	9817.22
278 M/S OTHER IMPLANTS	5970.00
300 LABORATORY GENERAL	33.00
301 LABORATORY CHEMISTRY	1561.00
305 LAB HEMATOLOGY	1152.00
307 LAB UROLOGY	124.00
312 LAB PATHOLOGY HISTOLOGY	1357.00
320 RADIOLOGY DIAG GENERAL	3011.00
360 OR SVCS GENERAL	17069.00
370 ANESTHESIA GENERAL	4873.00
410 RESPIRATORY SVC GENERAL	2024.00
460 PULMONARY FUNCTION GENERAL	286.00
636 DRUG SPEC ID DETAIL CODING	68.00
710 RECOVERY ROOM GENERAL	1296.00
730 EKG/ECG GENERAL	237.00
964 PROF FEES ANESTHETIST CRNA	4650.00
985 PROF FEES EKG	65.00
Billed charges to date:	70944.05



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

INSURANCE INFORMATION

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2300 OR (877) 835-0975, MONDAY-FRIDAY, 8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	08/06/07
Patient Name:	RICHARD A COOK
Date of Service:	06/26/07
Account Number:	H00028929271
Total Charges:	70944.05
Insurance Payments Received:	0.00
Adjustments to Insurance:	0.00
Patient Payments Received:	0.00

This is your balance:	70944.05

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER

LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
08/21/2007	08/06/07	H00028929271

AMOUNT DUE	SHOW AMOUNT PAID HERE
70944.05	$

651741B

PAGE: 1 of 1

0101

ADDRESSEE:

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555*T5F08P39K000891

OH00028929271000070944055273

Critical Health Systems of SC
PO Box 18089
Raleigh, NC 27619
(888) 280-9533

August 15, 2007

Richard Cook
121 Willma Ann Dr

Lexington, SC 29073

Account # L0807257646

Dear Richard Cook,

Critical Health Systems of SC provided your anesthesia or pain services during your recent medical procedure at Lexington Hospital. We were provided with incomplete insurance information. Please complete the enclosed form with correct and updated health insurance information, and mail it back to us in the envelope provided. You may also call us at the number below to supply this information.

If you do not have health insurance at this time, Critical Health Systems of SC does offer the following payment options:

1. Payment in Full (Cash, Check, Visa and MasterCard)
2. Monthly Payment Plan
3. Prompt Pay Discounts

Critical Health Systems of SC appreciates the opportunity to provide your anesthesia or pain services. As providers of this service, we do expect a prompt payment for all services rendered to you. After receiving your first bill, please contact our billing office at 919 873 9533 or toll free 888 280 9533, to speak with a patient service representative.

Thank you for your cooperation.

Para hablar con alguien que hable espanol, por favor llame al 1-888-280-9533 x326.

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS.
PITTS RADIOLOGICAL ASSOC., P.A.
PO Box 835
Oaks, PA 19456

10-27-06

OFFICE PHONE: 803-772-0198
Office Hours: 9AM - 4PM Mon. - Fri.

Fax: 803-772-4031

1192 - 14

RICHARD ASHFORD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073

Patient Name: RICHARD ASHFORD COOK
Account # 3624300216
Amount Due: $24.00

FINAL NOTICE!

According to our records, your balance of $24.00 is delinquent and remains unpaid to our practice. Please pay the amount in full immediately using the bottom portion of this letter or call 803-772-0198 to make payment arrangements.

If payment is not received within 10 days your account may be placed for collection without further involvement by PITTS RADIOLOGICAL ASSOC., P.A..

Please understand that failure to pay could adversely affect your credit rating.

Respond to this collection notice today.

CC: Collection Coordinator

FINAL NOTICE!

Please detach and return bottom portion with your payment in enclosed envelope

GUARANTOR NAME AND ADDRESS:

RICHARD ASHFORD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073

IF PAYING BY CREDIT CARD PLEASE FILL OUT BELOW		
☐ MASTERCARD ☐ VISA ☐ AMER. EXP.		
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

AMOUNT OF PAYMENT	$	Payment Due 11/6/06

SERVICES PROVIDED BY:

PITTS RADIOLOGICAL ASSOC., P.A.
P. O. BOX 2427
COLUMBIA SC 29202-2427

Patient Name: RICHARD ASHFORD COOK
Account #: 3624300216
Amount Due: $24.00

1 of 1

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

14 - 1192

PALMETTO HEALTH RICHLAND

P.O. BOX 402130
ATLANTA, GA 30384-2130

15970-U630

0101

STATEMENT DATE August 26, 2006

PAGE: 1 of 1

IF PAYING BY CREDIT CARD, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

PATIENT NAME AND ACCOUNT#		DATES OF SERVICE
RICHARD COOK R0622900132		08/17/2006 - 08/17/2006
ACCOUNT BALANCE	TOTAL CHARGES	AMOUNT PAID
$5,133.00	$5,133.00	$

652527B

[redacted] ADDRESSEE: [redacted]

RICHARD ASHFORD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

[redacted] REMIT TO: [redacted]

PALMETTO HEALTH RICHLAND
PO BOX 402111
ATLANTA, GA 30384-2111

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

15970-U630*1VS1663NO000376

PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT AND WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

ACCOUNT NUMBER	PATIENT NAME	ADMIT DATE	DISCH. DATE	TYPE	PC
R0622900132	RICHARD COOK	08/17/2006	08/17/2006		

Dear: RICHARD ASHFORD COOK,

Thank you for choosing Palmetto Health RICHLAND as your health care provider. No insurance was provided at the time of service for this visit; therefore, this bill represents the balance due.

Please send payment in full for the balance shown on the statement or contact our office for other arrangements.

Palmetto Health offers financial assistance to the underinsured or uninsured.

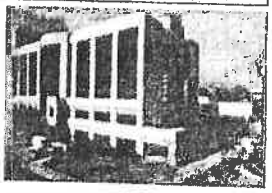
Patient Financial Services Department
296-5098 or call toll free 1-800-243-7711

YOU WILL RECEIVE A SEPARATE BILL FOR PHYSICIAN SERVICES

PREVIOUS BALANCE	ADJUSTMENTS	INSURANCE PAYMENTS	PATIENT PAYMENTS	ACCOUNT BALANCE	ESTIMATED INS. LIABILITY	PATIENT RESPONSIBILITY	PLEASE PAY THIS AMOUNT	
								$5,133.00

Note: Amounts indicated to be paid by third parties are estimated by the hospital. However, the patient and / or responsible party have personally guaranteed payment and are responsible for the total charges on this statement.

PALMETTO HEALTH RICHLAND



DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS

Lexington Radiology Associates, P.A.
PO Box 835
Oaks, PA 19456

FOR BILLING QUESTIONS,
PLEASE CALL 803-772-1778
Fax: 803-772-4031
Office Hours: 9AM - 4PM Mon. - Fri.

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ MASTERCARD ☐ VISA ☐ AMER. EXP. ☐ DISCOVER

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
08-26-06	$1,782.00	24606477

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

4382-54

RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

Lexington Radiology Associates, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608

Patient: RICHARD A COOK

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

Patient: RICHARD A COOK — **Referring Physician:MEARNS ROBERT**

Account No: 24606477 — **Services Were Provided at: LEXINGTON MEDICAL CENTER**

DATE	PROC CODE	DIAGNOSIS	UNITS	DESCRIPTION OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
07-01-06	74022	789.03	1	Abdomen Complete & Single View Cxr	92.00			92.00
07-01-06	74160	562.11	1	Ct Abdomen W/Contrast	252.00			252.00
07-01-06	72193	562.11	1	Ct Pelvis W/Contrast	242.00			242.00
07-05-06	74160	558.9	1	Ct Abdomen W/Contrast	252.00			252.00
07-05-06	72193	558.9	1	Ct Pelvis W/Contrast	242.00			242.00
07-05-06	71010	793.1	1	Chest, One View	30.00			30.00
07-15-06	71275	786.50	1	Ct Angiography, Chest	178.00			178.00
07-15-06	74160	573.8	1	Ct Abdomen W/Contrast	252.00			252.00
07-15-06	72193	573.8	1	Ct Pelvis W/Contrast	242.00			242.00
07-27-06				Statement Mailed				

Se habla espanol 866-729-7008

Current	31-60 Days	61-90 Days	Over 90 Days	PAYMENT DUE: 9/9/06	PATIENT BALANCE DUE : $1,782.00
$0.00	$1782.00	$0.00	$0.00		

YOUR ACCOUNT HAS BECOME PAST DUE! PLEASE AVOID FURTHER COLLECTION ACTION BY MAKING YOUR PAYMENT TODAY!

LEXINGTON RADIOLOGY ASSOCIATES, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608
803-772-1778
Tax ID: 57-0561785

STATEMENT

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

CONSULTANTS / GASTROENTEROLOGY
131 SUMMERPLACE DRIVE
WEST COLUMBIA SC 29169

134335

STATEMENT

ADDRESS SERVICE REQUESTED

☐ CHECK HERE For Credit Card Payment
SHOW AMOUNT PAID HERE $_____

(803) 939-4100	08/01/07	134335	01	1184.00
OFFICE PHONE NUMBER	CLOSING DATE	YOUR ACCOUNT NUMBER	PAGE NO.	PATIENT BALANCE

MR RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

CONSULTANTS / GASTROENTEROLOGY
131 SUMMERPLACE DRIVE
WEST COLUMBIA, SC 29169-3058

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
041307		CONSULT LEVEL 2	RICHARD	179.00	
051407		COLON BEYOND SPLENIC FLEXURE	RICHARD	1005.00	

CAROLINA PULMONARY AND CRITICA
PO BOX 127
COLUMBIA SC 29202

ADDRESS SERVICE REQUESTED

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA ☐ DISCOVER	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

005876S 0001/0001 1,3,6 00000 08062007 11036 853729 TU07 BNS L

REMIT TO:

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

CAROLINA PULMONARY AND CRITICA
PO BOX 127
COLUMBIA, SC 29202-0127

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
(803) 256-0464	08/06/07	168653	01	410.00	$

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

TE	PROVIDER / REFERRING PROVIDER EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	INSURANCE PENDING	PAYMENTS AND CREDITS	PATIENT BALANCE
	KIRSCHENFELD MD/LIBBEY					
1207	CPT: 99231 SUBSEQUENT HOSPITAL VISIT	R COOK	75.00			
***	Visit Totals:		75.00	0.00	0.00	75.00
	MAYSON MD/LIBBEY					
1007	CPT: 99253 CONSULT, INPT LEVEL 3	R COOK	185.00			
1107	CPT: 99231 SUBSEQUENT HOSPITAL VISIT LEVEL 1		75.00			
***	Visit Totals:		260.00	0.00	0.00	260.00
	THOMPSON ACNP/LIBBEY					
1307	CPT: 99231 SUBSEQUENT HOSPITAL VISIT	R COOK	75.00			
***	Visit Totals:		75.00	0.00	0.00	75.00

A $25 CHARGE MAY BE APPLIED FOR MISSED APPOINTMENTS

ement 08/06/07 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 168653

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	PATIENT BALANCE PAY THIS AMOUNT
410.00				410.00	410.00

D INQUIRIES / PAYMENTS TO:
CAROLINA PULMONARY AND CRITICA
PO BOX 127
COLUMBIA SC 29202
IRS #: 571054036

(803) 256-0464
PLEASE USE THE ENCLOSED PRE-ADDRESSED ENVELOPE FOR YOUR PAYMENT. CALL OUR OFFICE IF YOU HAVE ANY QUESTIONS.

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

ADDRESS SERVICE REQUESTED

STATEMENT

V18126 37
B5392M
TU15
BNS 003
1009 R

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

REMIT TO:

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
803-796-8901	08/14/06	1451449	1	4,240.00	$

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

ATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
0106	LIBBEY MD	ADMIT HOSPITAL LEVEL 2	RICHARD	225.00		
		Insurance Balance: 0.00		Patient Balance:		225.00
0506	LIBBEY MD	COLECTOMY END COLOSTOMY	RICHARD	3,500.00		
		Insurance Balance: 0.00		Patient Balance:		3,500.00
0506	LIBBEY MD	MOBIL SPLEN FLEXURE	RICHARD	515.00		
		Insurance Balance: 0.00		Patient Balance:		515.00

tement e: 08/14/06

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
4,015.00	225.00	0.00	0.00	4,240.00	0.00	4,240.00

ND INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-796-8901

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

CRITICAL HEALTH SYSTEMS OF SC
PO BOX 18089
RALEIGH, NC 27619

Statement Date	Amount Due	Account Number	Amount Paid
8/6/2007	2,184.00	L0607251646	

PAYMENT DUE	PLEASE CHARGE MY: ☐ VISA ☐ MasterCard	
8/21/2007	CARD NUMBER	AMOUNT
	SIGNATURE	EXP DATE

INSTREAM
Comprehensive Billing Services for the Anesthesia Profession

**********AUTO**3-DIGIT 290
RICHARD A COOK
PO BOX 84783
LEXINGTON SC 29073-0014

Make check payable to:
CRITICAL HEALTH SYSTEMS OF SC
PO BOX 18089
RALEIGH, NC 27619

To pay your bill on-line, please visit us at http://www.instreamservices.com/billpay.htm

This physician group does not work for the hospital and our services are not covered in the hospital bill.

Please detach the top portion and return with your payment. Keep the bottom portion for your records.

Statement of Account for Anesthesia or Pain Management Services

Patient Name	RICHARD A COOK	Account Number	L0607251646

Activity From	To	Description	Physician	Charges	Payments	Total
06/26/07	06/26/07	ANESTHESIA SERVICES	GROSSLIGHT	0.00	0.00	0.00
06/26/07	06/26/07	COLOSTOMY, CLOSURE	GROSSLIGHT	2,184.00	0.00	2,184.00

DUE TO RECENT ACTIVITY ON YOUR ACCOUNT, THIS BALANCE IS YOUR RESPONSIBILITY. IF YOU NEED TO MAKE ANY CHANGES TO YOUR ACCOUNT PLEASE CALL OUR OFFICE. THANK YOU

950

For Billing Questions, Please Call: (888) 280-9533
Si usted necesita ayuda en espanol, llame por favor 919-873-9533 o 888-280-9533.

Amount Due $ 2,184.00

CRITICAL HEALTH SYSTEMS OF SC
PO BOX 2344
COLUMBIA, SC 29202

Statement Date	Amount Due	Account Number	Amount Paid
8/18/2006	1,875.00	L0706195873	$

iNSTREAM
Comprehensive Billing Services for the Anesthesia Profession

PLEASE CHARGE MY: ☐ VISA ☐ MasterCard	
CARD NUMBER	AMOUNT
SIGNATURE	EXP DATE

**********AUTO**3-DIGIT 290
RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

Make check payable to:

CRITICAL HEALTH SYSTEMS OF SC
PO BOX 404773
ATLANTA, GA 303844773

This physician group does not work for the hospital and our services are not covered in the hospital bill.

Please detach the top portion and return with your payment. Keep the bottom portion for your records.

Statement of Account for Anesthesia or Pain Management Services

Patient Name	RICHARD A COOK	Account Number	L0706195873

Activity From	To	Description	Physician	Charges	Payments	Total
07/05/06	07/05/06	ANESTHESIA SERVICES	RICHARDS	0.00	0.00	0.00
07/05/06	07/05/06	LAPAROSCOPY, SURGICAL; COLECTOMY	RICHARDS	1,725.00	0.00	1,725.00
07/05/06	07/05/06	EMERGENCY CONDITIONS	RICHARDS	150.00	0.00	150.00

OUR RECORDS INDICATE THIS ACCOUNT IS PAST DUE. PLEASE REMIT WITHIN 15 DAYS TO AVOID FURTHER COLLECTION ACTIVITY.
THANK YOU

1725

For Billing Questions, Please Call: (888) 280-9533
Si usted necesita ayuda en espanol, llame por favor 919-873-9533 o 888-280-9533.

Amount: $ 1,875.00

077410 615020 P0070C R4169 SA26 BNS 015 0206 R

STATEMENT

SCOA
PO BOX 2046
WEST COLUMBIA SC 29171

ADDRESS SERVICE REQUESTED

☐ CHECK HERE For Credit Card Payment
SHOW AMOUNT PAID HERE $_____

(803) 461-3000	08/25/06	615020	01	4553.00
OFFICE PHONE NUMBER	CLOSING DATE	YOUR ACCOUNT NUMBER	PAGE NO.	PATIENT BALANCE

MR RICHARD COOK
121 WILLMA ANN RD
LEXINGTON, SC 29073-9307

SCOA
PO BOX 2046
WEST COLUMBIA, SC 29171-2046

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
072706	CHRISTIANSEN	EST OFFICE VISIT-LEVEL 3	RICHARD	77.00	
080906	CHRISTIANSEN	SKULL BASE TO KNEE PET/CT	RICHARD	3224.00	
080906	CHRISTIANSEN	FDG ADMINISTRATION	RICHARD	473.00	
080906	CHRISTIANSEN	FDG UP TO 45 MILLICURIES	RICHARD	325.00	
080906	CHRISTIANSEN	CBC W/AUTOMATED DIFF WBC COUNT	RICHARD	35.00	
080906	CHRISTIANSEN	VENIPUNCTURE	RICHARD	10.00	
080906	CHRISTIANSEN	BASIC METABOLIC PANEL	RICHARD	57.00	
080906	CHRISTIANSEN	LIVER PROFILE	RICHARD	40.00	
080906	CHRISTIANSEN	CEA	RICHARD	100.00	
081406	CHRISTIANSEN	EST OFFICE VISIT-LEVEL 4	RICHARD	106.00	
082106	CHRISTIANSEN	EST OFFICE VISIT-LEVEL 4	RICHARD	106.00	

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS

Pitts Radiological Assoc., P.A.
PO Box 835
Oaks, PA 19456

FOR BILLING QUESTIONS,
PLEASE CALL 803-772-0198
Fax: 803-772-4031
Office Hours: 9AM - 4PM Mon. - Fri.

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ MASTERCARD ☐ VISA ☐ AMER. EXP.

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO
04-19-07	$396.00	3708001151

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

4382-382

RICHARD ASHFORD COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

Pitts Radiological Assoc., P.A.
P. O. BOX 2427
COLUMBIA SC 29202-2427

Patient: RICHARD ASHFORD COOK

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

'atient: RICHARD ASHFORD COOK **Referring Physician CHRISTIANSEN NEAL P**

ccount No: 3708001151 **Services Were Provided at: PALMETTO HEALTH RICHLAND**

DATE	PROC CODE	DIAGNOSIS	UNITS	DESCRIPTION OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
3-21-07 4-11-07 4-03-07	36598	V58.81	1	Inj W/Fluor, Eval Cv Device McAid/Mcaid Hmo Denied Amt 396.00 Reas 26.Denied:Patient Not Eligible On Date Of Service Medicaid Submitted C26259373	396.00			396.00

Se habla espanol 866-729-7008

Current	31-60 Days	61-90 Days	Over 90 Days	PAYMENT DUE: 5/3/07	PATIENT BALANCE DUE : $396.00
$396.00	$0.00	$0.00	$0.00		

you have insurance please contact our office. You are sponsible for the amount indicated in PATIENT BALANCE UE.

PITTS RADIOLOGICAL ASSOC., P.A.
P. O. BOX 2427
COLUMBIA SC 29202-2427
803-772-0198
Tax ID: 57-0553185

1 of 1

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

382

RICHARD A COOK

Pathology Associates of Lexington, PA

Your Pathology Service Provider

Account #	Statement Date
GWD- 9140746-3	10/30/06

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

Due Date	Amount Due
11/14/06	450.00

IMPORTANT MESSAGE

SECOND NOTICE, PLEASE REMIT PROMPTLY.

YOUR PROMPT ATTENTION IS NEEDED. SEND BALANCE SHOWN BY DUE DATE. THANK YOU. CHECK PATHOLOGY GROUP'S WEBSITE: www.palpath.com (contains billing tips and help)

www.pathologybilling.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-877-268-1012
TOLL FREE FAX: 1-877-268-1254

Office hours:

Mon-Thur 8am-9pm EST
Fri 8am-8pm

Referring Physician:
JEFFREY LIBBEY MD

1

DATE	PROC. CODE	DESCRIPTION	QUANTITY	AMOUNT
07/06/06	8830926	MICROSCOPIC ANALYSIS, VI	1	450.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

207 1

PATHOLOGY ASSOCIATES OF LEXINGTON, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	DUE DATE	ACCOUNT #
10/30/06	11/14/06	GWD- 9140746-3

AMOUNT DUE
$ 450.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Patient Name: RICHARD A COOK

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-877-268-1012

ADDRESSEE:

RICHARD A COOK
127 WILMA ANN DR
LEXINGTON SC 29073-9307

MAKE CHECKS PAYABLE TO & REMIT TO:

PATHOLOGY ASSOCIATES OF LEXINGTON, PA
PO BOX 52990
GREENWOOD SC 29649-0048

Medical Collection Services of LMC

DEAR RICHARD A COOK:

WE ARE CONTACTING YOU REGARDING YOUR UNPAID BALANCE TO US. THE BALANCE IN THE AMOUNT OF $ 4859.00 NEEDS TO BE PAID IN FULL.

THIS IS AN ATTEMPT TO COLLECT A DEBT, ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE. UNLESS, WITHIN THIRTY (30) DAYS, YOU DISPUTE THE VALIDITY OF THIS DEBT OR ANY PORTION THEREOF, WE WILL ASSUME THIS DEBT IS VALID. IF YOU NOTIFY US IN WRITING WITHIN THIRTY (30) DAYS, WE WILL OBTAIN VERIFICATION OF THIS DEBT AND MAIL YOU A COPY FOR YOUR REVIEW.

NOTE: THE ABOVE STATEMENT IS NOT AUTHORIZATION TO DELAY PAYMENT ON A LEGAL DEBT. IF YOU HAVE ANY QUESTIONS REGARDING YOUR OUTSTANDING DEBT YOU MAY CONTACT US AT (803) 791-2100 OR E-MAIL US AT MCS@LEXHEALTH.ORG.

SINCERELY,

MEDICAL COLLECTION SERVICES OF LMC

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT

P.O. Box 100274
Columbia, SC 29202-3274

17196-Q951

June 29, 2007

PAGE NO. 1 of 1

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW.	
CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA	
CARD NUMBER	V-CODE
SIGNATURE	EXP. DATE
PATIENT NAME: RICHARD A COOK	ACCT. #: H28298883
BALANCE DUE: $4859.00	SHOW AMOUNT PAID HERE $

6324108

0101

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

MEDICAL COLLECTION SERVICES OF LMC
P.O. BOX 100274
COLUMBIA, SC 29202-3274

17196-Q951*T4C13EDGY000417

0000H28298883000004859008274

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS
PITTS RADIOLOGICAL ASSOC., P.A.
PO Box 1259
Oaks, PA 19456

OFFICE PHONE: 803-772-0198
Office Hours: 9AM - 4PM Mon. - Fri.

Fax: 803-772-4031

07-10-07

RICHARD ASHFORD COOK 1192-81
PO BOX 84783
LEXINGTON, SC 29073

Patient Name: RICHARD ASHFORD COOK
Account #: 3708500479
Amount Due: $953.00

FINAL NOTICE!

According to our records, your balance of $953.00 is delinquent and remains unpaid to our practice. Please pay the amount in full immediately using the bottom portion of this letter or call 803-772-0198 to make payment arrangements.

If payment is not received within 10 days your account may be placed for collection without further involvement by PITTS RADIOLOGICAL ASSOC., P.A..

Please understand that failure to pay could adversely affect your credit rating.

Respond to this collection notice today.

CC: Collection Coordinator

FINAL NOTICE!

Please detach and return bottom portion with your payment in enclosed envelope

GUARANTOR NAME AND ADDRESS:

RICHARD ASHFORD COOK
PO BOX 84783
LEXINGTON, SC 29073

IF PAYING BY CREDIT CARD PLEASE FILL OUT BELOW		
☐ MASTERCARD ☐ VISA ☐ AMER. EXP.		
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

AMOUNT OF PAYMENT	$	Payment Due 07/20/07

SERVICES PROVIDED BY:

PITTS RADIOLOGICAL ASSOC., P.A.
P. O. BOX 2427
COLUMBIA SC 29202-2427

Patient Name: RICHARD ASHFORD COOK
Account #: 3708500479
Amount Due: $953.00

1 of 1

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

81 - 1192

CRITICAL HEALTH SYSTEMS OF SC
PO BOX 2344
COLUMBIA, SC 29202

Statement Date	Amount Due	Account Number	Amount Paid
7/14/2006	1,875.00	L0706195873	$

INSTREAM
Comprehensive Billing Services for the Anesthesia Profession

PLEASE CHARGE MY: ☐ VISA ☐ MasterCard

CARD NUMBER	AMOUNT
SIGNATURE	EXP DATE

**********AUTO**3-DIGIT 290
RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

Make check payable to:
CRITICAL HEALTH SYSTEMS OF SC
PO BOX 404773
ATLANTA, GA 303844773

This physician group does not work for the hospital and our services are not covered in the hospital bill.

Please detach the top portion and return with your payment. Keep the bottom portion for your records.

Statement of Account for Anesthesia or Pain Management Services

Patient Name	RICHARD A COOK	Account Number	L0706195873

Activity From	To	Description	Physician	Charges	Payments	Total
07/05/06	07/05/06	ANESTHESIA SERVICES:				
07/05/06	07/05/06	LAPAROSCOPY, SURGICAL; COLECTOMY	RICHARDS	0.00	0.00	0.00
07/05/06	07/05/06	EMERGENCY CONDITIONS	RICHARDS	1,725.00	0.00	1,725.00
			RICHARDS	150.00	0.00	150.00

DUE TO RECENT ACTIVITY ON YOUR ACCOUNT, THIS BALANCE IS YOUR RESPONSIBILITY. IF YOU NEED TO MAKE ANY CHANGES TO YOUR ACCOUNT PLEASE CALL OUR OFFICE. THANK YOU

2036

For Billing Questions, Please Call: (888) 280-9533
Si usted necesita ayuda en espanol, llame por favor 919-873-9533 o 888-280-9533.

Amount: $ 1,875.00

ABOUT YOUR MEDICAL BILL

Our Business Services office is open for your convenience Monday through Friday from 8:30 a.m. to 5:30 p.m. You can reach us by telephone at (803) 791-2300.

Payment Options
The following payment options are available to help you pay the part of your bill not covered by your insurance:

- Pay your bill in full by cash, with a check, or credit card (MasterCard or Visa). Credit card payment is accepted by phone, mail or in person.
- Arrange an interest-free payment plan through our customer service representatives at (803) 791-2300.

Our representatives are available Monday-Friday from 8:30 a.m. - 5: 30 p.m to help you select one of the above payment options.

Toll-free (outside our local area) 1-877-835-0975

Our Location: 470 Hulon Lane
Our Office Hours: Monday–Friday 8:30 a.m.–5:30 p.m.

You may visit our website at www.LEXMED.com.
Please send any written correspondence to:

Lexington Medical Center
Patient Financial Services
P.O. Box 100273
Columbia, SC 29202-3273

MORE QUESTIONS

Questions regarding insurance payment should be directed to your insurance company(s).

You may visit our website at: www.LEXMED.com

LEXINGTON
MEDICAL CENTER

IF ANY OF THE INFORMATION ON THE FRONT HAS CHANGED PLEASE INDICATE BELOW...

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY | STATE | ZIP

TELEPHONE ( ) | MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME | TELEPHONE ( )

EMPLOYER'S ADDRESS | CITY | STATE | ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME | EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS | TELEPHONE ( )

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME | EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS | TELEPHONE ( )

CITY | STATE | ZIP

POLICYHOLDER'S ID NUMBER | GROUP PLAN NUMBER

651741B

Summary of Hospital Services and Charges

Account Number: 28298883

Date	Description	Amount	Date	Description	Amount
033107	CHEST, TWO VIEWS	$41.00			$41.00
033107	CT ANGIOGRAPHY, CHEST	$358.00			$358.00

Total Amount Due $399.00

If you require an itemized statement, please call: 803-772-1778

* * * * PLEASE SEE LETTER ON REVERSE SIDE * * * *

If we do not have insurance information please fill out information below.

Patient Name _____ Date of Birth _____ SS# _____ Marital Status ☐S ☐M ☐D ☐W

Street _____ Home Phone _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Employer Address _____

Insurance Company _____ Ins. Company Address _____

Subscriber/Cardholder Name _____ Relationship to Subscriber ☐Self ☐Spouse ☐Dependent ☐Other _____

Identification No. _____ Group No. _____

Job connected illness or injury? ☐Yes ☐No Auto Accident? ☐Yes ☐No Date of Onset or Accident: ____ / ____ / ____

Other Insurance Information _____

* If remitting payment, please make sure address on other side appears through window *

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

PATIENT INFORMATION

Your Name (Last, First, Middle Initial) | Date of Birth

Address

City | State | Zip

Telephone
( )

Social Security #

Employer's Name | Telephone
( )

Employer's Address

City | State | Zip

Please Indicate if Applicable:
☐ AUTO ACCIDENT
☐ WORKER'S COMPENSATION

Date of Injury

INSURANCE INFORMATION

Your **PRIMARY** Insurance Company's Name

Primary Insurance Company's Address

City | State | Zip

Policyholder Name | Date of Birth | Sex

Policyholder's ID Number | Group Plan Number

Your **SECONDARY** Insurance Company's Name

Secondary Insurance Company's Address

City | State | Zip

Policyholder Name | Date of Birth | Sex

Policyholder's ID Number | Group Plan Number

"DETACH HERE AND RETURN ABOVE STUB"

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN OR PROVIDER'S FEE

HOSPITAL CHARGES OR OTHER FACILITY

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.


612589A

LEXINGTON MEDICAL CENTER

07/10/07

PATIENT NAME: RICHARD A COOK
PATIENT ACCT#: H00028868800
DATE OF SERVICE: 05/14/07
AMOUNT DUE: $2575.98

Dear RICHARD A COOK:

Thank you for allowing us to serve your healthcare needs.

Although previous statements have been mailed to your address, our financial records indicate that you continue to have an outstanding balance due to Lexington Medical Center.

Please pay $2575.98 within twenty (20) days of the date of this letter. If you have not contacted our office for suitable arrangements or paid the balance in full by this deadline, your account will be referred to our collections department, Medical Collection Services, for further collection activity. These efforts could include, but are not limited to the following:

* Reporting this account as a bad debt to a credit reporting agency.
* A suit filed by the hospital in the local magistrate/circuit court.
* Referral of this account to a third party collection agency.
* A lien filed against any real property owned.
* Tax refund seizure through the SC Department of Tax & Revenue

If you have any questions regarding this balance, please do not hesitate to call our customer service department for assistance at (803) 791-2300 or toll free (877) 835-0975. If you have made this payment within the last five (5) days, please disregard this request.

Sincerely,

Customer Service
Patient Financial Services
Lexington Medical Center

10237-P555*T400JWVC8000300

LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, SC 29169
803-791-2000

RETURN SERVICE REQUESTED

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

IF PAYING BY MASTERCARD, VISA, CHECK OR MONEY ORDER, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT: ☐ MASTERCARD ☐ VISA ☐ CHECK / MONEY ORDER		
CARD NUMBER		SIGNATURE CODE
SIGNATURE		EXP. DATE
STATEMENT DATE: 07/10/07	PAY THIS AMOUNT: $2575.98	ACCT #: H00028868800
	SHOW AMOUNT PAID HERE $	

612589A

0101

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

10237-P555

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

0H00028868800000002575981273

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS

Lexington Radiology Associates, P.A.
PO Box 1259
Oaks, PA 19456

FOR BILLING QUESTIONS,
PLEASE CALL 803-772-1778
Fax: 803-772-4031
Office Hours: 9AM - 4PM Mon. - Fri.

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ MASTERCARD ☐ VISA ☐ AMEX. EXP. ☐ DISCOVER

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
07-21-07	$136.00	28929271

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

SEND TO:

4382-41

RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

REMIT TO: ***PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.***

Lexington Radiology Associates, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608

Patient: RICHARD A COOK

] Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

Patient: RICHARD A COOK — **Referring Physician LIBBEY JEFFREY S**

Account No: 28929271 — **Services Were Provided at: LEXINGTON MEDICAL CENTER**

DATE	PROC CODE	DIAGNOSIS	UNITS	DESCRIPTION OF SERVICES		CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
06-26-07	71010	58.81	1	Chest, One View	V	34.00			34.00
06-27-07	71010	86.05	1	Chest, One View	7	34.00			34.00
06-29-07	71010	514	1	Chest, One View		34.00			34.00
06-30-07	71010	58.82	1	Chest, One View	V	34.00			34.00

Se habla espanol 866-729-7008

Current	31-60 Days	61-90 Days	Over 90 Days
$136.00	$0.00	$0.00	$0.00

PAYMENT DUE: 08/04/07

PATIENT BALANCE DUE : $136.00

If you have insurance please contact our office. You are responsible for the amount indicated in PATIENT BALANCE DUE.

LEXINGTON RADIOLOGY ASSOCIATES, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608
803-772-1778
Tax ID: 57-0561785

1 of 1

STATEMENT

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

UNIV SPECIALTY CLINICS SURGERY
2 RICHLAND MED PK 402
COLUMBIA SC 29203

STATEMENT

ADDRESS SERVICE REQUESTED

10246
B5372M
SA16
BNS 011
0233 R

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

REMIT TO:

UNIV SPECIALTY CLINICS SURGERY
2 RICHLAND MED PK 402
COLUMBIA, SC 29203

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
(803) 256-2657	09/15/06	GS22885	01	93.00	$

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER / REFERRING PROVIDER EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	INSURANCE PENDING	PAYMENTS AND CREDITS	PATIENT BALANCE
	BELL MD/CHRISTIANSEN MD					
32206	OFFICE/OUTPATIENT VISIT, NEW, INTERMEDIA		93.00			
*****	Visit Totals:		93.00	0.00	0.00	93.00

tement e: 09/15/06

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: GS22885

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	PATIENT BALANCE PAY THIS AMOUNT
93.00				93.00	0.00	93.00

ID INQUIRIES / PAYMENTS TO:
UNIV SPECIALTY CLINICS SURGERY
2 RICHLAND MED PK 402
COLUMBIA SC 29203

(803) 256-2657
PLEASE USE THE ENCLOSED PRE-ADDRESSED ENVELOPE FOR YOUR PAYMENT. CALL OUR OFFICE IF YOU HAVE ANY QUESTIONS.

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

CONSULTANTS / GASTROENTEROLOGY
131 SUMMERPLACE DRIVE
WEST COLUMBIA SC 29169

134335

STATEMENT

BALANCE DUE IN FULL/ ACCOUNT IS IN REVIEW FOR COLLECTIONS!!!

ADDRESS SERVICE REQUESTED

☐ CHECK HERE For Credit Card Payment
SHOW AMOUNT PAID HERE $_____

(803) 939-4100	07/02/07	134335	01	1184.00
OFFICE PHONE NUMBER	CLOSING DATE	YOUR ACCOUNT NUMBER	PAGE NO.	PATIENT BALANCE

MR RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

CONSULTANTS / GASTROENTEROLOGY
131 SUMMERPLACE DRIVE
WEST COLUMBIA, SC 29169-3058

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
041307		CONSULT LEVEL 2	RICHARD	179.00	
051407		COLON BEYOND SPLENIC FLEXURE	RICHARD	1005.00	

P.O. Box 1984
Southgate, MI 48195-0984

Receivable Solutions, Inc.

P.O. BOX 6678
Columbia, SC 29260
866-505-7419 (Toll Free)

08/08/07

RSI/00100/1114539/222004216735 0000484 0000385/0003

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

Client: LEXINGTON RADIOLOGY ASSOCIATES, P.A.
HALL THOMAS R
Account #: 28298883
File #: 1114539
Balance: $399.00

This letter is a courtesy notification that your seriously delinquent account, captioned above, is now in our hands for collections.

Please call 1-803-744-3113 or 1-866-505-7419 to discuss settlement of your account.

Unless you notify this office within thirty days after receiving this notice that you dispute the validity of the debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within thirty days from receiving this notice that you dispute the validity of this debt or any portion thereof, this office will obtain verification of the debt or obtain a copy of a judgment and mail you a copy of such judgment or verification. If you request this office in writing within 30 days after receiving this notice this office will provide you with the name and address of the original creditor, if different from the current creditor.

Sincerely,

Receivable Solutions, Inc.

This is an attempt to collect a debt and any information received will be used for that purpose. In addition this communication is from a debt collector.

***** Please detach below and return in the enclosed envelope with your payment *****

Circle One: VISA MasterCard

Account Number:_____

Name on Card: _____

Expiration Date: _____/_____ CCV#: _____(Last 3 digits on back of card)

Signature: _____

Client: LEXINGTON RADIOLOGY ASSOCIATES, P.A.
Account: 28298883
File #: 1114539
Balance: $399.00

Amount Paid: $_____

Receivable Solutions, Inc.
P.O. Box 6678
Columbia, SC 29260-6678

00100

CONSULTANTS IN GASTROENTEROLOGY, PA
131 SUMMERPLACE DRIVE
WEST COLUMBIA, SC 29169
(803) 939-4100

July 18, 2007

Richard Cook
Po Box 84783
Lexington, SC 29073

Account #: CIG 134335

Account Balance:$1184.00

Dear Mr. Cook,

Unfortunately, we had no response from our previous letter. Your account has become delinquent and requires immediate attention. The remaining balance is your responsibility.

We would appreciate your payment in full for this balance. If you have already paid your account in full, we apologize for the inconvenience and thank you for your payment.

Thank you for entrusting Consultants in Gastroenterology with your healthcare needs and for your prompt payment.

Sincerely,

Susan Bickley
Financial Counselor
803-939-4100 ext 150
sbickley@scgastro.com

Sharron Sedgwick
Financial Counselor
803-939-4100 Ext 169
Collections@scgastro.com

You may pay this bill by Visa or Mastercard.
Account # CIG 134335 Amount $1184.00

Credit Card:_____Card Expires:_____/_____
Month Year

Card Number:_____

Security Code _____
(Last 3 digits of number in signature area on back of card)

Print Card Holders Name:_____

Signature:_____

CRITICAL HEALTH SYSTEMS OF SC
PO BOX 18089
RALEIGH, NC 27619

Statement Date	Amount Due	Account Number	Amount Paid
8/13/2007	702.00	L0807257646	

PAYMENT DUE	PLEASE CHARGE MY: ☐ VISA ☐ MasterCard	
8/28/2007	CARD NUMBER	AMOUNT
	SIGNATURE	EXP DATE / CVV#

INSTREAM
Comprehensive Billing Services for the Anesthesia Profession

**********AUTO**3-DIGIT 290
RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

Make check payable to:
CRITICAL HEALTH SYSTEMS OF SC
PO BOX 18089
RALEIGH, NC 27619

To pay your bill on-line, please visit us at http://www.instreamservices.com/billpay.htm

This physician group does not work for the hospital and our services are not covered in the hospital bill.

Please detach the top portion and return with your payment. Keep the bottom portion for your records.

Statement of Account for Anesthesia or Pain Management Services

Patient Name	RICHARD A COOK	Account Number	L0807257646

Activity From	To	Description	Physician	Charges	Payments	Total
08/02/07	08/02/07	ANESTHESIA SERVICES	KNIGHT	0.00	0.00	0.00
08/02/07	08/02/07	ACCESS TO CENTRAL VENOUS	KNIGHT	702.00	0.00	702.00

DUE TO RECENT ACTIVITY ON YOUR ACCOUNT, THIS BALANCE IS YOUR RESPONSIBILITY. IF YOU NEED TO MAKE ANY CHANGES TO YOUR ACCOUNT PLEASE CALL OUR OFFICE. THANK YOU

1847

For Billing Questions, Please Call: (888) 280-9533
Si usted necesita ayuda en espanol, llame por favor 919-873-9533 o 888-280-9533.

Amount Due $ 702.00

1SDNAFA11
PO Box 1022
Wixom MI 48393-1022
ADDRESS SERVICE REQUESTED

FROST - ARNETT COMPANY
The Collection Company
(615)256-7156 / (800) 264-7156

August 16, 2007

MAIL ALL CORRESPONDENCE TO:

FROST- ARNETT COMPANY
PO Box 198988
Nashville TN 37219-8988

#BWNHRMD 0207967 0011730
#0816 1131 0011 7303# PJ3902-0M1

Richard A Cook
PO Box 84783
Lexington SC 29073-0014

Account Number _____ Exp Date ____/____

Card Holder Name _____ $_____ Pmt Amt

Signature of Card Holder _____ Date ____/____/____

Detach Upper Portion and Return with Payment

This is a communication from a debt collector.
This is an attempt to collect a debt.
Any information obtained will be used for that purpose.

Account Number: PJ3902
Total Balance: $624.00

YOU OWE: CRITICAL HEALTH SYSTEMS L0507244363 624.00

Reputation...It takes years to build up a good one, but a few careless deeds to destroy it.

It is an honor to receive a bill for a bill is an indication that someone has faith in your honesty.

Credit is the most priceless thing you have. Money can be had by various means, but credit comes only from years of honesty and prompt meeting of bills when they are due.

Pay in full today!

1SDNAFA110M1

NOTICE: When you pay your bill by check, you authorize us to electronically process your payment. If your check is processed electronically, your checking account may be debited on the same day we receive the check and it will not be returned with your checking account statement. If someone other than you or a bill paying service pays your bill, you must give a copy of this notice to them before the payment is sent to us. Any check returned for insufficient funds or account closed may be assessed a processing fee pursuant to state laws.

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

STATEMENT

V18126 37
B5392M
TH12
IIM 001
1214 R

ADDRESS SERVICE REQUESTED

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance
803-939-8989	07/11/07	1451449	1	CONTINUED

PLEASE RETURN THIS PORTION WITH PAYMENT
SHOW AMOUNT PAID HERE $_____

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
41107	LIBBEY MD	ESTAB PATIENT EXAM -LEVEL CALLED MCAID VRU, PT NOT ELIGIBLE FOR MCAID ON THI DOS	RICHARD	77.00		
		Insurance Balance: 0.00		Patient Balance:		77.00
42007	NORTON MD	EXTREMITY VENOUS	RICHARD	460.00		
		Insurance Balance: 0.00		Patient Balance:		460.00
50407	LIBBEY MD	ESTAB PATIENT EXAM - LEVE	RICHARD	55.00		
		Insurance Balance: 0.00		Patient Balance:		55.00
52207	LIBBEY MD	ESTAB PATIENT EXAM -LEVEL	RICHARD	77.00		
		Insurance Balance: 0.00		Patient Balance:		77.00
52607	MOORE JR MD	INTERRUPTION INF VENA CAV	RICHARD	1,300.00		
		Insurance Balance: 0.00		Patient Balance:		1,300.00
2607	MOORE JR MD	PERCUTAN PLCMT IVC FILTER	RICHARD	210.00		
		Insurance Balance: 0.00		Patient Balance:		210.00
2607	MOORE JR MD	INTRO CATH VENA CAVA	RICHARD	250.00		
		Insurance Balance: 0.00		Patient Balance:		250.00
2607	MOORE JR MD	VENOGRAPHY CAVAL INFERIOR	RICHARD	320.00		
		Insurance Balance: 0.00		Patient Balance:		320.00
2607	MOORE JR MD	INS CENTRAL VEN CATH >5YR	RICHARD	453.00		

ement
: 07/11/07 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

PATIENT BALANCE
PAY THIS AMOUNT
CONTINUED

) INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-939-8989

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

ADDRESS SERVICE REQUESTED

V18126 37
B5392M
TH12
IIM 001
1215 R

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK

REMIT TO:

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	PLEASE RETURN THIS PORTION WITH PAYMENT
803-939-8989	07/11/07	1451449	2	8,636.00	SHOW AMOUNT PAID HERE $

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
		Insurance Balance: 0.00				
				Patient Balance:		453.00
52607	LIBBEY MD	CLOS ENTEROSTOMY				
		Insurance Balance: 0.00	RICHARD	3,700.00		
				Patient Balance:		3,700.00
52607	LIBBEY MD	BX LIVER WEDGE				
		Insurance Balance: 0.00	RICHARD	1,200.00		
				Patient Balance:		1,200.00
52607	LIBBEY MD	REM CENT VEN CATH				
		Insurance Balance: 0.00	RICHARD	534.00		
				Patient Balance:		534.00

ment 07/11/07 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
8,044.00	0.00	592.00	0.00	8,636.00	0.00	8,636.00

INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-939-8989

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

STATEMENT

016156 1451449

CUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
EST COLUMBIA, SC 29169

DDRESS SERVICE REQUESTED

V18126 37
B5392M
SA1S
BNS 003
2579 R

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

REMIT TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
803-796-8901	07/14/06	1451449	1	225.00	$

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

ATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
)106	LIBBEY MD	ADMIT HOSPITAL LEVEL 2	RICHARD	225.00		
		Insurance Balance: 0.00		Patient Balance:		225.00

Statement Date: 07/14/06

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
225.00	0.00	0.00	0.00	225.00	0.00	225.00

SEND INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-796-8901

LEXINGTON COUNTY EMS
5005 SUNSET BLVD.
LEXINGTON, SC 29072

0101

RETURN SERVICE REQUESTED

SECOND NOTICE

PAGE: 1 of 1

ADDRESSEE:

COOK, RICHARD
121 WILMA ANN DR
LEXINGTON, SC 29073-9307

☐ Please check if above address is incorrect and indicate change on reverse side.

You may use our secure web site to pay by Credit Card: www.emsbillingsc.com

PIN # 2780

CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA

CARD NUMBER		SIGNATURE CODE
SIGNATURE		EXP. DATE

DATE	ACCOUNT NUMBER	PAYMENT
08/23/2006	671803	

PATIENT NAME	AMOUNT DUE:
COOK, RICHARD	$425.00

MAKE CHECK PAYABLE / REMIT TO:

651941A

LEXINGTON COUNTY EMS
5005 SUNSET BLVD.
LEXINGTON, SC 29072

13315-G521*1VP0G6178000475

PLEASE WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK OR MONEY ORDER.

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

PATIENT ACCOUNT STATEMENT

STATEMENT DATE	PATIENT ACCOUNT NO.	PATIENT NAME
08/23/2006	671803	COOK, RICHARD

SERVICE DATE	RUN NO.	DESCRIPTION	UNITS	PROC DATE	CHARGES	PAYMENT / ADJ.	PATIENT DUE
07/01/06	0611021	Previous Balance Due ..					425.00

SIGNATURE REQUIRED ON BACK OF STUB FOR INSURANCE PURPOSES

****THIS STATEMENT CANNOT BE USED TO FILE MEDICARE ****

SECOND NOTICE

THIS IS YOUR SECOND NOTICE. PAYMENT IS DUE BY REMIT DATE.

TOTAL AMOUNT	$425.00
SERVICES RENDERED BY	LEXINGTON COUNTY EMS
TAX I.D. #	576000379

TOLL-FREE PHONE: (800) 533-3915
LOCAL: (803)957-7111
HOURS: 8:00AM-5:00PM
MONDAY THRU FRIDAY

13315-G521*1VP0G6178000475

1VP0G7MZ5:1.1

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

STATEMENT

V18126 37
B5392M
FR10
IIM 001
1960 L

ADDRESS SERVICE REQUESTED

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD	☐ VISA
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance
803-939-8989	08/09/07	1451449	1	CONTINUED

PLEASE RETURN THIS PORTION WITH PAYMENT
SHOW AMOUNT PAID HERE $_____

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
41107	LIBBEY MD	ESTAB PATIENT EXAM -LEVEL CALLED MCAID VRU, PT NOT ELIGIBLE FOR MCAID ON THI DOS	RICHARD	77.00		
		Insurance Balance: 0.00			Patient Balance:	77.00
42007	NORTON MD	EXTREMITY VENOUS	RICHARD	460.00		
		Insurance Balance: 0.00			Patient Balance:	460.00
50407	LIBBEY MD	ESTAB PATIENT EXAM - LEVE	RICHARD	55.00		
		Insurance Balance: 0.00			Patient Balance:	55.00
52207	LIBBEY MD	ESTAB PATIENT EXAM -LEVEL	RICHARD	77.00		
		Insurance Balance: 0.00			Patient Balance:	77.00
52607	MOORE JR MD	INTERRUPTION INF VENA CAV	RICHARD	1,300.00		
		Insurance Balance: 0.00			Patient Balance:	1,300.00
52607	MOORE JR MD	PERCUTAN PLCMT IVC FILTER	RICHARD	210.00		
		Insurance Balance: 0.00			Patient Balance:	210.00
52607	MOORE JR MD	INTRO CATH VENA CAVA	RICHARD	250.00		
		Insurance Balance: 0.00			Patient Balance:	250.00
52607	MOORE JR MD	VENOGRAPHY CAVAL INFERIOR	RICHARD	320.00		
		Insurance Balance: 0.00			Patient Balance:	320.00
52607	MOORE JR MD	INS CENTRAL VEN CATH >5YR	RICHARD	453.00		

ement
: 08/09/07

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

PATIENT BALANCE
PAY THIS AMOUNT
CONTINUED

D INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-939-8989

Budget Due: $50.00
Non-budget: $8,044.00
N
N

Please pay: $8,094.00

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

1451449

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

ADDRESS SERVICE REQUESTED

STATEMENT

V18126 37
B5392M
FR10
IIM 001
1961 L

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK

REMIT TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
803-939-8989	08/09/07	1451449	2	8,636.00	$_____

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

TE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
		Insurance Balance: 0.00		Patient Balance:		453.00
	607 LIBBEY MD	CLOS ENTEROSTOMY	RICHARD	3,700.00		
		Insurance Balance: 0.00		Patient Balance:		3,700.00
	607 LIBBEY MD	BX LIVER WEDGE	RICHARD	1,200.00		
		Insurance Balance: 0.00		Patient Balance:		1,200.00
	607 LIBBEY MD	REM CENT VEN CATH	RICHARD	534.00		
		Insurance Balance: 0.00		Patient Balance:		534.00

ment 08/09/07 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
0.00	8,044.00	0.00	592.00	8,636.00	0.00	8,636.00

) INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-939-8989

Budget Due: $50.00
Non-budget: $8,044.00
N
N

Please pay: $8,094.00

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

LEXINGTON MEDICAL CENTER

08/03/07

PATIENT NAME: RICHARD A COOK
PATIENT ACCT#: H00025754409
DATE OF SERVICE: 09/26/06
AMOUNT DUE: $75.00

Dear RICHARD A COOK:

Thank you for allowing us to serve your healthcare needs.

Although previous statements have been mailed to your address, our financial records indicate that you continue to have an outstanding balance due to Lexington Medical Center.

Please pay $75.00 within twenty (20) days of the date of this letter. If you have not contacted our office for suitable arrangements or paid the balance in full by this deadline, your account will be referred to our collections department, Medical Collection Services, for further collection activity. These efforts could include, but are not limited to the following:

* Reporting this account as a bad debt to a credit reporting agency.
* A suit filed by the hospital in the local magistrate/circuit court.
* Referral of this account to a third party collection agency.
* A lien filed against any real property owned.
* Tax refund seizure through the SC Department of Tax & Revenue

If you have any questions regarding this balance, please do not hesitate to call our customer service department for assistance at (803) 791-2300 or toll free (877) 835-0975. If you have made this payment within the last five (5) days, please disregard this request.

Sincerely,

Customer Service
Patient Financial Services
Lexington Medical Center

10237-P555.*T5C0TV6X5000406

LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, SC 29169
803-791-2000

RETURN SERVICE REQUESTED

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

IF PAYING BY MASTERCARD, VISA, CHECK OR MONEY ORDER, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA ☐ CHECK / MONEY ORDER

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
08/03/07	$75.00	H00025754409

SHOW AMOUNT PAID HERE $

612589A

0101

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

10237-P555

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

0H00025754409000000075000273

STATEMENT OF SERVICES

FROM:

IMAGECARE, L.L.C.
P.O. BOX 1247
COVINGTON, GA 30015-1247

Tax ID #: 57-1017301
For billing questions call: 800-879-6274

TO:

RICHARD ASHFO COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on back of statement.

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW

☐ MasterCard ☐ VISA

CARD NUMBER	EXPIRATION DATE
SIGNATURE	STATEMENT DATE 09/30/06

PAST DUE DATE	ACCOUNT NUMBER	PAY THIS AMOUNT
10/25/06	0622900132	391.00

PATIENT NAME: RICHARD ASHFO COOK
SHOW AMOUNT PAID HERE: $

MAKE CHECKS PAYABLE TO:

IMAGECARE, L.L.C.
P.O. BOX 1247
COVINGTON, GA 30015-1247

PLEASE PUT ACCOUNT NUMBER ON CHECK - DETACH AND RETURN THIS TOP PORTION WITH YOUR PAYMENT. THANK YOU.

ACCOUNT NO.	STMT. DATE	PATIENT	DATE OF BIRTH
RRC-0622900132	09/30/06	RICHARD ASHFO COOK	12/09/62

DATE	#	PROCEDURE CODE	DESCRIPTION OF SERVICES*	DX CODE	AMOUNT
08/17/06		76360	CT-BIOPSY GUIDED-INTEPR		176.00
08/17/06		10022	FINE NEEDLE ASPIRATION W/IMAGIN		215.00

IF YOU HAVE INSURANCE, PLEASE ATTACH A COPY OF THIS ITEMIZED STATEMENT TO YOUR CLAIM FORM AND MAIL TO YOUR INSURANCE. RESPONSIBILITY FOR PAYMENT IS YOURS.

$25 Service Charge for Returned Checks

ATTENDING PHYSICIAN:
JACQUETTE L CALDWELL, MD

REFERRING PHYSICIAN:
NEAL P CHRISTIANSEN

BALANCE DUE
391.00

PRACTICE NAME:
IMAGECARE, L.L.C.
800-879-6274

LOCATION OF SERVICE:
RICHLAND MEMORIAL HOSP

*REFER TO BACK FOR PLACE OF SERVICE CODES

PALMETTO HEALTH RICHLAND

P.O. BOX 402130
ATLANTA, GA 30384-2130

15970-U630

0101

STATEMENT DATE September 09, 2006

PAGE: 1 of 1

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

PATIENT NAME AND ACCOUNT#	DATES OF SERVICE
RICHARD COOK R0624300216	08/31/2006 - 08/31/2006

ACCOUNT BALANCE	TOTAL CHARGES	AMOUNT PAID
$7,641.00	$7,641.00	$

6525278

ADDRESSEE:

RICHARD ASHFORD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

REMIT TO:

PALMETTO HEALTH RICHLAND
PO BOX 402111
ATLANTA, GA 30384-2111

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

15970-U630*1W61667E2000431

PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT AND WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

ACCOUNT NUMBER	PATIENT NAME	ADMIT DATE	DISCH. DATE	TYPE	FC
R0624300216	RICHARD COOK	08/31/2006	08/31/2006		

Dear: RICHARD ASHFORD COOK,

Thank you for choosing Palmetto Health RICHLAND as your health care provider. No insurance was provided at the time of service for this visit; therefore, this bill represents the balance due.

Please send payment in full for the balance shown on the statement or contact our office for other arrangements.

Palmetto Health offers financial assistance to the underinsured or uninsured.

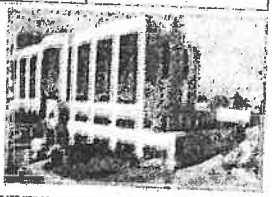
Patient Financial Services Department
296-5098 or call toll free 1-800-243-7711

YOU WILL RECEIVE A SEPARATE BILL FOR PHYSICIAN SERVICES

PREVIOUS BALANCE	ADJUSTMENTS	INSURANCE PAYMENTS	PATIENT PAYMENTS	ACCOUNT BALANCE	ESTIMATED INS. LIABILITY	PATIENT RESPONSIBILITY	PLEASE PAY THIS AMOUNT	
								$7,641.00

Note: Amounts indicated to be paid by third parties are estimated by the hospital. However, the patient and / or responsible party have personally guaranteed payment and are responsible for the total charges on this statement.

PALMETTO HEALTH RICHLAND



131 SUMMERPLACE DRIVE
WEST COLUMBIA SC 29169

STATEMENT

ADDRESS SERVICE REQUESTED

☐ CHECK HERE For Credit Card Payment
SHOW AMOUNT PAID HERE $_____

(803) 939-4100	05/01/07	134335	01	179.00
OFFICE PHONE NUMBER	CLOSING DATE	YOUR ACCOUNT NUMBER	PAGE NO.	PATIENT BALANCE

MR RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

CONSULTANTS / GASTROENTEROLOGY
131 SUMMERPLACE DRIVE
WEST COLUMBIA, SC 29169-3058

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
041307		CONSULT LEVEL 2	RICHARD	179.00	

DOCTOR'S FEE-MAKE CK TO:CONSULTANTS IN GASTROENTEROLOGY

STATEMENT CLOSING DATE: 05/01/07 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 134335

PATIENT BALANCE PAY THIS AMOUNT 179.00

SEND INQUIRIES TO:
CONSULTANTS / GASTROENTEROLOGY
131 SUMMERPLACE DRIVE
WEST COLUMBIA SC 29169

(803) 939-4100
IF YOU HAVE ANY QUESTIONS ABOUT THIS BILL, PLEASE CALL OUR OFFICE

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403

WEST COLUMBIA SC 29169
Tax Id#: 570874077

oup#: 37

v#	Servdate	Rp	Dept	Dr	Fac	Ref	Proc	M1	M2	Desc	Diag 1	Ins/Comment	Amount	Resp Bal	Ins Bal
tient#: 1451449 COOK, RICHARD A.															
	07/01/06	1	GS	740	50	1557	99222			ADMIT HOSP	562.11		225.00	.00	.00
	11/22/06						MCAIDPMT			MEDICAID PMT		4852867	-86.22		
	11/22/06						MCAIDADJ			MEDICAID ADJU			-138.78		
	07/05/06	1	GS	740	50		44143			COLECTOMY END	562.11		3500.00	.00	.00
	11/22/06						MCAIDPMT			MEDICAID PMT		4852867	-1022.11		
	11/22/06						MCAIDADJ			MEDICAID ADJU			-2477.89		
	07/05/06	1	GS	740	50		44139			MOBIL SPLEN F	562.11		515.00	.00	.00
	11/22/06						MCAIDPMT			MEDICAID PMT		4852867	-45.83		
	11/22/06						MCAIDADJ			MEDICAID ADJU			-469.17		
	07/21/06	1	GS	740	37	1557	99024			POST OP VISIT	562.11		.00	.00	.00
	08/04/06	1	GS	740	37	1557	99024			POST OP VISIT	562.11		.00	.00	.00
	09/06/06	1	GS	740	37	1557	99024			POST OP VISIT	562.11		.00	.00	.00
	10/27/06	1	GS	740	37	1557	99024			POST OP VISIT	562.11		.00	.00	.00
	11/02/06	1	GS	740	37		VOCRHB			VOC REHAB MR	MISC		15.00	.00	.00
	11/02/06						11			PAT CHECK PMT		127974003	-15.00		
	03/09/07	1	GS	740	37	1557	99024			POST OP VISIT	562.11		.00	.00	.00
0	04/11/07	1	GS	740	37	1557	99213			ESTAB PATI	562.11		77.00	77.00	.00
1	04/20/07	1	VL	743	37	740	93970			EXTREMITY	V12.52		460.00	460.00	.00
2	05/04/07	1	GS	740	37	1557	99212			ESTAB PATI	562.11		55.00	55.00	.00
3	06/22/07	1	GS	740	37	1300	99213			ESTAB PATI	562.11		77.00	77.00	.00
4	06/26/07	1	GS	741	50	741	37620			INTERR INT VE	453.40		1300.00	1300.00	.00
5	06/26/07	1	GS	741	50	741	75940	26		PERCUT PL IVC	453.40		210.00	210.00	.00
6	06/26/07	1	GS	741	50	741	36010			INTR CATH VEN	453.40		250.00	250.00	.00
7	06/26/07	1	GS	741	50	741	75825	26		VENOGRAPHY CA	453.40		320.00	320.00	.00
8	06/26/07	1	GS	741	50	741	36556	52	RT	INS CENT VEN	453.40		453.00	453.00	.00
9	06/26/07	1	GS	740	50		44626			CLOS ENTEROST	153.9		3700.00	3700.00	.00
0	06/26/07	1	GS	740	50		47100	59		BX LIVER WEDG	197.7		1200.00	1200.00	.00
1	06/26/07	1	GS	740	50		36590	RT		REM CNT VN CA	996.1		534.00	534.00	.00
2	07/11/07	1	GS	740	37	1300	99024			POST OP VISIT	562.11		.00	.00	.00
3	07/25/07	1	GS	740	37	1300	99024			POST OP VISIT	153.9		.00	.00	.00
:4	08/08/07	1	GS	740	37		99024			POST OP VISIT	153.9		.00	.00	.00

3) AA NONE

--> Resp Charges :	8651.00	Pays :	-15.00	Adjs :	.00	Bal Due : 8636.00
--> Ins Charges :	4240.00	Pays :	-1154.16	Adjs :	-3085.84	Bal Due : .00
--> Charges :	12891.00	Pays :	-1169.16	Adjs :	-3085.84	Bal Due : 8636.00

---

2) Patient Name 1451449 COOK, RICHARD A.

--> Resp Charges :	8651.00	Pays :	-15.00	Adjs :	.00	Bal Due : 8636.00
--> Ins Charges :	4240.00	Pays :	-1154.16	Adjs :	-3085.84	Bal Due : .00
--> Charges :	12891.00	Pays :	-1169.16	Adjs :	-3085.84	Bal Due : 8636.00

---

1) Group# 37 SOUTHERN SURGICAL GROUP

--> Resp Charges :	8651.00	Pays :	-15.00	Adjs :	.00	Bal Due : 8636.00
--> Ins Charges :	4240.00	Pays :	-1154.16	Adjs :	-3085.84	Bal Due : .00
--> Charges :	12891.00	Pays :	-1169.16	Adjs :	-3085.84	Bal Due : 8636.00

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403

WEST COLUMBIA SC 29169
Tax Id#: 570874077

nv#	Servdate	Rp	Dept	Dr	Fac	Ref	Proc	M1	M2	Desc	Diag 1	Ins/Comment	Amount	Resp Bal	Ins Bal

rand Totals :	--> Resp Charges :	8651.00	Pays :	-15.00	Adjs :	.00	Bal Due :	8636.00
	--> Ins Charges :	4240.00	Pays :	-1154.16	Adjs :	-3085.84	Bal Due :	.00
	--> Charges :	12891.00	Pays :	-1169.16	Adjs :	-3085.84	Bal Due :	8636.00

arameters Used To Select This Report :
EPORT OPTION : Detail
REELINE OPTION : No Freelines
DDITIONAL DATA OPTION : No Additional Information
irst Selection Parameters:

1451449

STATEMENT

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

ADDRESS SERVICE REQUESTED

V18126 37
B5392M
WE13
BNS 003
2652 R

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

REMIT TO:

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE $
803-939-8989	09/12/06	1451449	1	4,240.00	

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

E	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
	06 LIBBEY MD	ADMIT HOSPITAL LEVEL 2	RICHARD	225.00		
		Insurance Balance: 0.00		Patient Balance:		225.00
	06 LIBBEY MD	COLECTOMY END COLOSTOMY	RICHARD	3,500.00		
		Insurance Balance: 0.00		Patient Balance:		3,500.00
	06 LIBBEY MD	MOBIL SPLEN FLEXURE	RICHARD	515.00		
		Insurance Balance: 0.00		Patient Balance:		515.00

ment 09/12/06 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
0.00	4,240.00	0.00	0.00	4,240.00	0.00	4,240.00

INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-939-8989

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS
Lexington Radiology Associates, P.A.
PO Box 835
Oaks, PA 19456

FOR BILLING QUESTIONS,
PLEASE CALL 803-772-1778
Fax: 803-772-4031
Office Hours: 9AM - 4PM Mon. - Fri.

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ MASTERCARD ☐ VISA ☐ AMER. EXP. ☐ DISCOVER

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
07-27-06	$1,782.00	24606477

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

SEND TO:

4382-240

RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

REMIT TO:

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

Lexington Radiology Associates, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608

Patient: RICHARD A COOK

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

Patient: RICHARD A COOK — **Referring Physician: MEARNS ROBERT**

Account No: 24606477 — **Services Were Provided at: LEXINGTON MEDICAL CENTER**

DATE	PROC CODE	DIAGNOSIS	UNITS	DESCRIPTION OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
07-01-06	74022	789.03	1	Abdomen Complete & Single View Cxr	92.00			92.00
07-01-06	74160	562.11	1	Ct Abdomen W/Contrast	252.00			252.00
07-01-06	72193	562.11	1	Ct Pelvis W/Contrast	242.00			242.00
07-05-06	74160	558.9	1	Ct Abdomen W/Contrast	252.00			252.00
07-05-06	72193	558.9	1	Ct Pelvis W/Contrast	242.00			242.00
07-05-06	71010	793.1	1	Chest, One View	30.00			30.00
07-15-06	71275	786.50	1	Ct Angiography, Chest	178.00			178.00
07-15-06	74160	573.8	1	Ct Abdomen W/Contrast	252.00			252.00
07-15-06	72193	573.8	1	Ct Pelvis W/Contrast	242.00			242.00

Se habla espanol 866-729-7008

Current	31-60 Days	61-90 Days	Over 90 Days
$1782.00	$0.00	$0.00	$0.00

PAYMENT DUE: 8/10/06

PATIENT BALANCE DUE : $1,782.00

IF YOU HAVE INSURANCE PLEASE CALL OUR OFFICE.
THIS IS THE ONLY STATEMENT YOU WILL RECEIVE!

LEXINGTON RADIOLOGY ASSOCIATES, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608
803-772-1778
Tax ID: 57-0561785

1 of 1

STATEMENT

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

240

LEXINGTON COUNTY EMS
5005 SUNSET BLVD.
LEXINGTON, SC 29072

0101

RETURN SERVICE REQUESTED

PLEASE REMIT

PAGE: 1 of 1

ADDRESSEE:

COOK, RICHARD
121 WILMA ANN DR
LEXINGTON, SC 29073-9307

☐ Please check if above address is incorrect and indicate change on reverse side.

You may use our secure web site to pay by Credit Card: www.emsbillingsc.com

PIN # 2780

CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA

CARD NUMBER		SIGNATURE CODE
SIGNATURE		EXP. DATE

DATE	ACCOUNT NUMBER	PAYMENT
07/24/2006	671803	

PATIENT NAME	AMOUNT DUE:
COOK, RICHARD	$425.00

651941A

MAKE CHECK PAYABLE / REMIT TO:

LEXINGTON COUNTY EMS
5005 SUNSET BLVD.
LEXINGTON, SC 29072

13315-H753*1UV0I8QZT000028

PLEASE WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK OR MONEY ORDER.

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

PATIENT ACCOUNT STATEMENT

STATEMENT DATE	PATIENT ACCOUNT NO.	PATIENT NAME
07/24/2006	671803	COOK, RICHARD

SERVICE DATE	RUN NO	DESCRIPTION	UNITS	PROC. DATE	CHARGES	PAYMENT / ADJ	PATIENT DUE
07/01/06	0611021	Ambulance Service					
07/01/06	0611021	From: RESIDENCE					
07/01/06	0611021	To: Lexington Medical C					
07/01/06	0611021	TRANSPORT-RESIDENT	1	07/01/06	425.00		425.00

SIGNATURE REQUIRED ON BACK OF STUB FOR INSURANCE PURPOSES

** THIS STATEMENT CANNOT BE USED TO FILE MEDICARE **

PLEASE REMIT

********** PAYMENT IS DUE WITHIN 20 DAYS **********

IF YOU HAVE INSURANCE, PLEASE FILL OUT THE BACK OF THIS FORM AND RETURN IT TO US IN THE ENVELOPE PROVIDED.

****

THIS SERVICE IS NOT AFFILIATED WITH THE HOSPITAL!! YOU MUST CONTACT * YOUR OFFICE WITH QUESTIONS REGARDING YOUR BILL. *

****

THANK YOU

TOTAL AMOUNT	$425.00
[illegible]	LEXINGTON COUNTY EMS
TAX I.D. #	576000379

TOLL-FREE PHONE: (800) 533-3915
LOCAL: (803)957-7111
HOURS: 8:00AM-5:00PM
MONDAY THRU FRIDAY

13315-H753*1UV0I8QZT000028

1UV0IP5UT:1.1

SCOA
PO BOX 2046
WEST COLUMBIA SC 29171

615020

STATEMENT

ADDRESS SERVICE REQUESTED

☐ CHECK HERE For Credit Card Payment
SHOW AMOUNT PAID HERE $_____

(803) 461-3000	03/09/07	615020	01	73.20
OFFICE PHONE NUMBER	CLOSING DATE	YOUR ACCOUNT NUMBER	PAGE NO.	PATIENT BALANCE

MR RICHARD A COOK
121 WILLMA ANN RD
LEXINGTON, SC 29073-9307

SCOA
PO BOX 2046
WEST COLUMBIA, SC 29171-2046

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
		BALANCE FORWARD		6530.90	
022107	CHRISTIANSEN	BASIC METABOLIC PANEL	RICHARD	57.00	
022107	CHRISTIANSEN	LIVER PROFILE	RICHARD	40.00	
022107	CHRISTIANSEN	CEA	RICHARD	100.00	
022107	CHRISTIANSEN	MAGNESIUM	RICHARD	22.00	
022207	CHRISTIANSEN	NEGOTIATED PATIENT W/O	RICHARD		-45.00
022207	CHRISTIANSEN	NEGOTIATED PATIENT W/O	RICHARD		-164.00
022207	CHRISTIANSEN	NEGOTIATED PATIENT W/O	RICHARD		-150.00
022207	CHRISTIANSEN	NEGOTIATED PATIENT W/O	RICHARD		-106.00
022207	CHRISTIANSEN	NEGOTIATED PATIENT W/O	RICHARD		-2178.65
022307	CHRISTIANSEN	PORT FLUSH	RICHARD		-264.00
022807	CHRISTIANSEN	SCOA CARES ADJUSTMENT	RICHARD	75.00	

Pitts Professionals Services, LLC
PO Box 388
Orangeburg SC 29116

Billing Office: 1728 Villagepark Drive.Orangeburg, SC 29116
Phone: 803/534-0053 Toll Free: 800/461-0929

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ MasterCard ☐ VISA

CARD NUMBER	AMOUNT
NAME ON CARD (PLEASE PRINT)	EXP. DATE
SIGNATURE	

STATEMENT DATE	ACCOUNT #	PAY THIS AMOUNT
09/22/2006	569-QSC01	$409.00

Patient: RICHARD COOOK

AMOUNT PAID

183 1 AT 0.308 *3 00183
Richard Coook
121 Wilma Ann Drive
Lexington SC 29073-9307

MAKE CHECK PAYABLE & REMIT TO:

Pitts Professionals Services, LLC
PO Box 388
Orangeburg SC 29116-0388

PLEASE CHECK BOX IF ABOVE ADDRESS IS INCORRECT AND INDICATE CHANGES ON BACK

THERADI1-0121977-0000183-0725698-001-000010-#000193

DETACH HERE AND RETURN THIS TOP PORTION WITH YOUR PAYME USING THE RETURN ENVELOPE ENCLOSED

DATE	CODE	DESCRIPTION	AMOUNT	INS	ADJUST	PAID	OWE
08/09/06	78815-26	CHARGES FOR PATIENT: RICHARD COOOK (569-QSC01) TUMORIMAGE PET/CT SKUL	$409.00				$409.00
		08/17/06 GUARANTOR RESPONSIBILITY DATE (ChargeID: 494)					
		ADDITIONAL INFORMATION CONCERNING YOUR ACCOUNT					
		WE HAVENT RECEIVED YOUR PAYMENT. YOUR ACCOUNT IS NOW DELINQUENT.					
		RENDERING PROVIDER 30 IS SAMUEL FRIEDMAN - TAX ID: 204844348					

CCOUNT CONDITION: Current: $0.00 30 Days: $409.00 60 Days: $0.00 90 Days: $0.00 120 Days: $0.00

BALANCE DUE: $409.00

ient: RICHARD COOOK Account Number: 569-QSC01 Statement Date: 09/22/2006

Pitts Professionals Services, LLC
PO Box 388
Orangeburg SC 29116

THERADI1-0121977-0000183-0725698-001-000010-#000193

Phone: 803/534-0053 Toll Free: 800/461-0929

421 Fayetteville Street
Suite 600
Raleigh, NC 27601

ABSOLUTE
COLLECTION
SERVICE

919-755-3900
FAX 919-755-390.

Date: 9/12/2006

**********AUTO**MIXED AADC 275
RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

DEBTOR #: A19816359
REFERENCE #: L0706195873
DATE OF SERVICE: 7/5/06

Dear Richard A Cook:

Critical Health Systems turned your account over to our office for collection. They have authorized us to extend to you a courtesy which allows you thirty (30) days in order to pay the balance on your account and prevent further, more serious collection activity.

Our records indicate that your account balance is $1,875.00 for services rendered to you on 7/5/06.

If you like, you may call our office to charge your balance to either your Check Card, MasterCard or Visa account.

All portions of this claim shall be assumed valid unless disputed in writing within thirty (30) days; in which case, verification of the debt or a copy of the judgment will be provided to you. If the original creditor is different from the above named creditor, the name of the original creditor will be provided upon request.

This is an attempt to collect a debt. Any information obtained will be used for that purpose only.

Sincerely,

Charlton Clarkson
Account Representative

CC:je

Hours of Operation: (EST) Monday - Thursday: 8:30 am - 9:00 pm, Friday: 8:30 am - 6:00 pm, Saturday: 8:00 am - 1:00 pm

(Detach the bottom portion and return with your payment. Keep the top portion for your records.)

Complete the information below to remit payment with Mastercard, Visa.

CHECK CARD USING FOR PAYMENT: ☐ VISA ☐ MasterCard

DEBTOR #: A19816359
REFERENCE #: L0706195873

Cardholder Name: _____ Amount: _____

Card Number: _____ Expiration Date: _____

Authorized Signature: _____

ck this box if your address is incorrect or insurance information has changed. Please ate the change(s) on reverse of this form.

N.C. Department of Insurance Permit #988

4850

YOUR STATEMENT

Thank you for allowing us to serve your healthcare needs.Our records indicate no insurance coverage for this bill and the balance is your responsibility. Please pay the balance in full by the date shown or contact Customer Serivce.

SUMMARY OF CHARGES

250 PHARMACY GENERAL	68.00
258 PHARMACY IV SOLUTIONS	65.00
270 M/S SUPPLY GENERAL	250.98
370 ANESTHESIA GENERAL	480.00
636 DRUG SPEC ID DETAIL CODING	34.00
710 RECOVERY ROOM GENERAL	336.00
750 GASTROINTENTINAL GENERAL	742.00
964 PROF FEES ANESTHETIST CRNA	600.00
Billed charges to date:	2575.98

INSURANCE INFORMATION

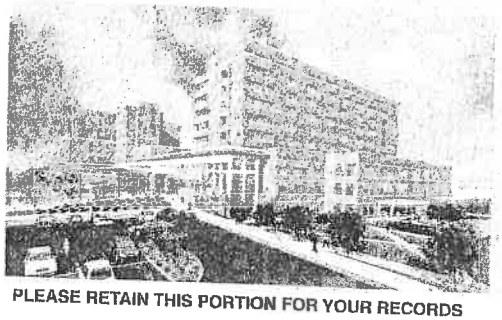
10237-P555

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2300 OR (877) 835-0975, MONDAY-FRIDAY, 8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	05/21/07
Patient Name:	RICHARD A COOK
Date of Service:	05/14/07
Account Number:	H00028868800
Total Charges:	2575.98
Insurance Payments Received:	0.00
Adjustments to Insurance:	0.00
Patient Payments Received:	0.00



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

This is your balance: 2575.98

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
06/05/2007	05/21/07	H00028868800
2575.98	SHOW AMOUNT PAID HERE $	

651741B

PAGE: 1 of 1

0101

ADDRESSEE:

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

0H00028868800000002575981273

10237-P555*T3A0BYJD5000907

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS.
PITTS RADIOLOGICAL ASSOC., P.A.
PO Box 1259
Oaks, PA 19456

OFFICE PHONE: 803-772-0198
Office Hours: 9AM - 4PM Mon. - Fri.

Fax: 803-772-4031

05-19-07

RICHARD ASHFORD COOK 1192-35
PO BOX 84783
LEXINGTON, SC 29073

Patient Name: RICHARD ASHFORD COOK
Account #: 3708001151
Amount Due: $396.00

FINAL NOTICE!

According to our records, your balance of $396.00 is delinquent and remains unpaid to our practice. Please pay the amount in full immediately using the bottom portion of this letter or call 803-772-0198 to make payment arrangements.

If payment is not received within 10 days your account may be placed for collection without further involvement by PITTS RADIOLOGICAL ASSOC., P.A..

Please understand that failure to pay could adversely affect your credit rating.

Respond to this collection notice today.

CC: Collection Coordinator

FINAL NOTICE!

Please detach and return bottom portion with your payment in enclosed envelope

GUARANTOR NAME AND ADDRESS:

RICHARD ASHFORD COOK
PO BOX 84783
LEXINGTON, SC 29073

IF PAYING BY CREDIT CARD PLEASE FILL OUT BELOW

☐ MASTERCARD ☐ VISA ☐ AMER. EXP.

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

AMOUNT OF PAYMENT	$

Payment Due 5/29/07

Patient Name: RICHARD ASHFORD COOK
Account #: 3708001151
Amount Due: $396.00

SERVICES PROVIDED BY:

PITTS RADIOLOGICAL ASSOC., P.A.
P. O. BOX 2427
COLUMBIA SC 29202-2427

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

35 - 1192

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

STATEMENT

V18126 37
B5392M
TU15
BNS 002
0128 L

ADDRESS SERVICE REQUESTED

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
803-939-8989	05/14/07	1451449	1	592.00	$

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

ATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
107	LIBBEY MD	ESTAB PATIENT EXAM -LEVEL CALLED MCAID VRU, PT NOT ELIGIBLE FOR MCAID ON THI DOS	RICHARD	77.00		
		Insurance Balance: 0.00			Patient Balance:	77.00
007	NORTON MD	EXTREMITY VENOUS	RICHARD	460.00		
		Insurance Balance: 0.00			Patient Balance:	460.00
407	LIBBEY MD	ESTAB PATIENT EXAM - LEVE	RICHARD	55.00		
		Insurance Balance: 0.00			Patient Balance:	55.00

nent 05/14/07 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
515.00	77.00	0.00	0.00	592.00	0.00	592.00

INQUIRIES / PAYMENTS TO:
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-939-8989

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS.
LEXINGTON RADIOLOGY ASSOCIATES, P.A.
PO Box 835
Oaks, PA 19456

09-26-06

OFFICE PHONE: 803-772-1778
Office Hours: 9AM - 4PM Mon. - Fri.

Fax: 803-772-4031

RICHARD A COOK 1169 - 47
121 WILLMA ANN DR
LEXINGTON, SC 29073

Patient Name: RICHARD A COOK
Account #: 24606477
Amount Due: $1782.00

FINAL NOTICE!

According to our records, your balance of $1782.00 is delinquent and remains unpaid to our practice. Please pay the amount in full immediately using the bottom portion of this letter or call 803-772-1778 to make payment arrangements.

If payment is not received within 10 days your account may be placed for collection without further involvement by LEXINGTON RADIOLOGY ASSOCIATES, P.A..

Please understand that failure to pay could adversely affect your credit rating.

Respond to this collection notice today.

CC: Collection Coordinator

FINAL NOTICE!

Please detach and return bottom portion with your payment in enclosed envelope

GUARANTOR NAME AND ADDRESS:

RICHARD A COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073

IF PAYING BY CREDIT CARD PLEASE FILL OUT BELOW		
☐ MASTERCARD ☐ VISA ☐ AMER. EXP. ☐ DISCOVER		
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

AMOUNT OF PAYMENT	$

Payment Due 10/6/06

Patient Name: RICHARD A COOK
Account #: 24606477
Amount Due: $1782.00

SERVICES PROVIDED BY:

LEXINGTON RADIOLOGY ASSOCIATES, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608

1 of 1

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

47 - 1169

421 Fayetteville Street Mall
Suite 600
Raleigh, NC 27601

ABSOLUTE
COLLECTION
SERVICE

919-755-3900
FAX 919-755-3903

Date: 10/09/2006

**********AUTO**3-DIGIT 290
RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

DEBTOR #: A19816359
REFERENCE #: L0706195873
DATE OF SERVICE: 7/5/06

Dear Richard A Cook:

We have written you previously concerning your seriously past due account with Critical Health Systems. Be advised that since you did not respond to our initial request for payment, we have initiated further, more serious collection activity. You can prevent this from appearing on your credit report by contacting our office immediately with payment in full or to make satisfactory payment arrangements.

It is imperative that you mail your payment of $1,875.00 for services rendered to you on 7/5/06to our office today. Make your check or money order payable to ACS and include a copy of this letter with your payment. You may use a MASTERCARD or VISA to settle your account by calling our office at the number listed above.

This is an attempt to collect a debt. Any information obtained will be used for that purpose only.

Sincerely,

Charlton Clarkson
Account Representative

CC:je

Hours of Operation: (EST) Monday - Thursday: 8:30 am - 9:00 pm, Friday: 8:30 am - 6:00 pm, Saturday: 8:00 am - 1:00 pm

(Detach the bottom portion and return with your payment. Keep the top portion for your records.)

Complete the information below to remit payment with Mastercard, Visa.

CHECK CARD USING FOR PAYMENT: ☐ VISA ☐ MasterCard

DEBTOR #: A19816359
REFERENCE #: L0706195873

Cardholder Name: _____ Amount: _____

Card Number: _____ Expiration Date: _____

Authorized Signature: _____

] Check this box if your address is incorrect or your insurance information has changed. Please indicate the change(s) on reverse of this form.

N.C. Department of Insurance Permit #988

40888

[redacted]

PLEASE SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS

Pitts Radiological Assoc., P.A.
PO Box 835
Oaks, PA 19456

FOR BILLING QUESTIONS,
PLEASE CALL 803-772-0198
Fax: 803-772-4031
Office Hours: 9AM - 4PM Mon. - Fri.

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ MASTERCARD ☐ VISA ☐ AMER. EXP.

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
09-27-06	$24.00	3624300216

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

4382-871

RICHARD ASHFORD COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

Pitts Radiological Assoc., P.A.
P. O. BOX 2427
COLUMBIA SC 29202-2427

Patient: RICHARD ASHFORD COOK

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

Patient: RICHARD ASHFORD COOK **Referring Physician: CHRISTIANSEN NEAL P**

Account No: 3624300216 **Services Were Provided at: PALMETTO HEALTH RICHLAND**

DATE	PROC CODE	DIAGNOSIS	UNITS	DESCRIPTION OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
08-31-06	70360	153.9	1	Neck Soft Tissues	24.00			24.00

Se habla espanol 866-729-7008

Current	31-60 Days	61-90 Days	Over 90 Days	PAYMENT DUE: 10/11/06	PATIENT BALANCE DUE : $24.00
$24.00	$0.00	$0.00	$0.00		

F YOU HAVE INSURANCE PLEASE CALL OUR OFFICE.
HIS IS THE ONLY STATEMENT YOU WILL RECEIVE!

PITTS RADIOLOGICAL ASSOC., P.A.
P. O. BOX 2427
COLUMBIA SC 29202-2427
803-772-0198
Tax ID: 57-0553185

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

871

UNIV SPECIALTY CLINICS SURGERY
2 RICHLAND MED PK 300
COLUMBIA SC 29203

ADDRESS SERVICE REQUESTED

10246
B5372M
TH26
BNS 007
2644 R

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

UNIV SPECIALTY CLINICS SURGERY
2 RICHLAND MED PK 300
COLUMBIA, SC 29203

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance
(803) 256-2657	04/25/07	GS22885	01	15.00

PLEASE RETURN THIS PORTION WITH PAYMENT
SHOW AMOUNT PAID HERE $

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER / REFERRING PROVIDER EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	INSURANCE PENDING	PAYMENTS AND CREDITS	PATIENT BALANCE
	BELL MD/CHRISTIANSEN MD					
82206	OFFICE/OUTPATIENT VISIT, NEW, INTERMEDIA		93.00			
11606	MEDICAL RECORDS PAYMENT				-15.00	
*****	Visit Totals:		93.00	78.00	-15.00	0.00
11606	MEDICAL RECORDS FEE		15.00			
*****	Visit Totals:		15.00	0.00	0.00	15.00

tement
e: 04/25/07

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: GS22885

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	PATIENT BALANCE PAY THIS AMOUNT
			93.00	93.00	78.00	15.00

ID INQUIRIES / PAYMENTS TO:
UNIV SPECIALTY CLINICS SURGERY
2 RICHLAND MED PK 300
COLUMBIA SC 29203

(803) 256-2657
THIS IS YOUR FINAL BILL. YOUR ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY IF PYMT IS NOT RECEIVED WITHIN 15 DAYS

NOTE: Charges and payments not appearing on this statement will appear on next month's statement

Professional
HOSPITAL SERVICES
Palmetto Health

April 18, 2007

R0708500479
RICHARD ASHFORD COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

Patient Name: RICHARD COOK
PALMETTO HEALTH RICHLAND
Account #: R0708500479
Current Balance: $9,184.00
DATE OF SERVICE: 03/26/2007

Dear RICHARD ASHFORD COOK:

Your account with Palmetto Health has been assigned to our self pay department, Professional Hospital Services, for follow up. We are unaware of any insurance coverage or payment arrangements that may have been made to cover this balance.

As the self pay department of Palmetto Richland Memorial Hospital, we want to work with you toward the successful resolution of this balance. If you are unable to pay this balance in full, please contact us at (803) 296-7900 or 1-800-499-5962 to obtain additional information or to establish a payment plan.

NOTE: Palmetto Health offers Financial Assistance to our uninsured and under insured patients that meet certain guidelines.

Thank you.

J. Ross (PHS)
PATIENT REPRESENTATIVE
(803) 296-7924
BD66

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

MAKE CHECKS PAYABLE TO:

Professional
HOSPITAL SERVICES
Palmetto Health

293 GREYSTONE BLVD.
FIRST FLOOR
COLUMBIA, SC 29210

RETURN SERVICE REQUESTED

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMER.CAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
04/18/07	$9,184.00	R0708500479

SHOW AMOUNT PAID HERE $

612528A

101

RICHARD ASHFORD COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

15970-U631

PROFESSIONAL HOSPITAL SERVICES
PO BOX 402111
ATLANTA, GA 30384-2111

15970-U631*T2D166Q3J000357

PALMETTO HEALTH RICHLAND

P.O. BOX 402130
ATLANTA, GA 30384-2130

0101

15970-U630

STATEMENT DATE March 14, 2007

PAGE: 1 of 1

IF MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

PATIENT NAME AND ACCOUNT#	DATES OF SERVICE
RICHARD COOK R0706401659	03/05/2007 - 03/05/2007

ACCOUNT BALANCE	TOTAL CHARGES	AMOUNT PAID
$765.00	$765.00	$

652527B

[redacted] ADDRESSEE:

RICHARD ASHFORD COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

[redacted] REMIT TO:

PALMETTO HEALTH RICHLAND
PO BOX 402111
ATLANTA, GA 30384-2111

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

15970-U630*T1E1671JF000348

PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT AND WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

ACCOUNT NUMBER	PATIENT NAME	ADMIT DATE	DISCH. DATE	TYPE	FC
R0706401659	RICHARD COOK	03/05/2007	03/05/2007		

Dear: RICHARD ASHFORD COOK,

Thank you for choosing Palmetto Health RICHLAND as your health care provider. No insurance was provided at the time of service for this visit; therefore, this bill represents the balance due.

Please send payment in full for the balance shown on the statement or contact our office for other arrangements.

Palmetto Health offers financial assistance to the underinsured or uninsured.

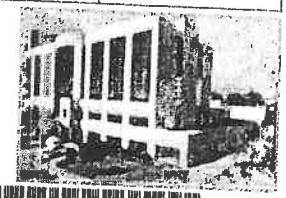
Patient Financial Services Department
296-5098 or call toll free 1-800-243-7711

YOU WILL RECEIVE A SEPARATE BILL FOR PHYSICIAN SERVICES

PREVIOUS BALANCE	ADJUSTMENTS	INSURANCE PAYMENTS	PATIENT PAYMENTS	ACCOUNT BALANCE	ESTIMATED INS. LIABILITY	PATIENT RESPONSIBILITY	PLEASE PAY THIS AMOUNT	
								$765.00

Note: Amounts indicated to be paid by third parties are estimated by the hospital. However, the patient and / or responsible party have personally guaranteed payment and are responsible for the total charges on this statement.

PALMETTO HEALTH RICHLAND



Date: 3/29/2007
Creditor: PITTS PROFESSIONAL
Balance: 409.00
Account: 97429-68387

Phone #: (828)394-4142

RICHARD COOK
121 WILLMA ANN RD
LEXINGTON, SC 29073

REMIT TO:
TRINITY HOPE ASSOCIATES
PO BOX 1916
LENOIR, NC 28645.

The above client has referred your account to our office for collections. We ask that you immediately contact our office to pay the balance in full. For your convenience, we gladly accept check payments by phone at no additional cost to you. If you prefer to mail payment by check or money order, please make check payable to Trinity Hope Associates and include the account number listed above. Keep in mind that any check returned for non-sufficient funds or closed accounts will be charged a $35.00 processing fee.

Unless you notify our office within (30) days of receiving this notice that you dispute the validity of the debt or any portion thereof, our office will assume that this debt is valid. If you notify our office in writing within (30) days of receiving this notice, our office will obtain verification of the debt or obtain a copy of the judgment if any, against you and mail you a copy of such verification or judgment. If you request from our office in writing within thirty (30) days of receiving this notice, our office will provide you with the name and address of the original creditor, if differnt from the current creditor.

If payment or notice of dispute is not received at our office within (30) days of the date of this letter, we will update your credit report at Equifax with the account information listed above.

We thank you in advance for your payment. This letter is from a collection agency and this is an attempt to collect a debt. Any information obtained will be used for that purpose.

ACCT #	CLIENT	AMOUNT	INT	FEES	TOTAL
97429	PITTS PROFESSIONAL	409.00	0.00	0.00	409.00

Sincerely,
Kim Caudill
Collections Department

N.C. Dept. of Ins. Permit # 4202

Pathology Associates of Lexington, PA

Your Pathology Service Provider

RICHARD A COOK

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

Account #	Statement Dat
GWD- 9140746-3	09/20/06

Due Date	Amount Due
Upon Receipt	450.00

IMPORTANT MESSAGE

FIRST NOTICE, PLEASE REMIT PROMPTLY.

In order to process your insurance, PSA needs complete insurance information. Please send your payment or contact us with any insurance, Medicaid or Medicare information. CHECK PATHOLOGY GROUP'S WEBSITE: www.palpath.com (contains billing tips and help)

www.pathologybilling.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-877-268-1012
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 8am-9pm EST
Fri 8am-8pm

Referring Physician:
JEFFREY LIBBEY MD

1

DATE	PROC. CODE	DESCRIPTION	QUANTITY	AMOUNT
07/06/06	8830926	MICROSCOPIC ANALYSIS, VI	1	450.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

115 1

PATHOLOGY ASSOCIATES OF LEXINGTON, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	DUE DATE	ACCOUNT #
09/20/06	Upon Receipt	GWD- 9140746-3

AMOUNT DUE
$ 450.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

atient Name: RICHARD A COOK

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

ADDRESSEE:

RICHARD A COOK
127 WILMA ANN DR
LEXINGTON SC 29073-9307

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-877-268-1012

MAKE CHECKS PAYABLE TO & REMIT TO:

PATHOLOGY ASSOCIATES OF LEXINGTON, PA
PO BOX 52990
GREENWOOD SC 29649-0048

5959 South Sherwood Forest Boulevard • Baton Rouge, Louisiana 70816
Phone: 225.292.2031 • Fax: 225.295.9642
amedisys.com

Amedisys Home Health Services

Date 3/20/07

Patient: Richard Cook
Account #: I1033560
Service Date: 7/10-11/12/06
Amount Due : $2674.07

Dear: Richard Cook ,

Our nurses and entire staff were pleased to serve you during your need for medical services. Our records indicate that the above balance is due.

Please mail your payment along with the lower portion of this letter. If payment has been made, please accept our thanks and disregard this notice.

If you have any questions concerning your account, please feel free to call me at 800-946-8773. Your cooperation is very much appreciated .

Sincerely,

Jeri Lorio

Accounts Representative

PLEASE RETURN LOWER PORTION WITH YOUR PAYMENT

Amedisys
PO Box 62600
New Orleans, La 70162

Patient: Richard Cook
Account #: I1033560
Service Date: 7/10-11/12/06
Amount Due: $2674.07

Amedisys
Home Health Services

RICHARD A COOK

Professional Pathology Services, PC PCCL
Your Pathology Service Provider

Account #	Statement Date
PSA- 7862033-7	04/03/07
Due Date	**Amount Due**
04/18/07	11.00

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

IMPORTANT MESSAGE

FIRST NOTICE, PLEASE REMIT PROMPTLY.

In order to process your insurance, PSA needs complete insurance information. Please send your payment or contact us with any insurance, Medicaid or Medicare information. Thank You!

www.pathologybilling.com
e-mail: psabilling@psapath.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-800-849-8085
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 8am-9pm ET
Fri 8am-8pm

Referring Physician:
NEAL P CHRISTIANSEN

1

DATE	PROC. CODE	DESCRIPTION	QUANTITY	AMOUNT
03/26/07	8573026	THROMBOPLASTIN TIME (PTT)	1	6.00
03/26/07	8561026	PROTHROMBIN TIME	1	5.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

PROFESSIONAL PATHOLOGY SERVICES, PC PCCL
PO BOX 100559
FLORENCE SC 29501-0559

STATEMENT DATE	DUE DATE	ACCOUNT #
04/03/07	04/18/07	PSA- 7862033-7

AMOUNT DUE
$ 11.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Patient Name: RICHARD A COOK

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-800-849-8085

ADDRESSEE:

01-A S 00246

RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

MAKE CHECKS PAYABLE TO & REMIT TO:

PROFESSIONAL PATHOLOGY SERVICES, PC PCCL
PO BOX 6256
FLORENCE SC 29502-6256

LEXINGTON
MEDICAL CENTER

01/12/07

PATIENT NAME: RICHARD A COOK
PATIENT ACCT#: H00024606477
DATE OF SERVICE: 07/01/06
AMOUNT DUE: $60.00

Dear RICHARD A COOK:

Thank you for allowing us to serve your healthcare needs.

Although previous statements have been mailed to your address, our financial records indicate that you continue to have an outstanding balance due to Lexington Medical Center.

Please pay $60.00 within twenty (20) days of the date of this letter. If you have not contacted our office for suitable arrangements or paid the balance in full by this deadline, your account will be referred to our collections department, Medical Collection Services, for further collection activity. These efforts could include, but are not limited to the following:

* Reporting this account as a bad debt to a credit reporting agency.
* A suit filed by the hospital in the local magistrate/circuit court.
* Referral of this account to a third party collection agency.
* A lien filed against any real property owned.
* Tax refund seizure through the SC Department of Tax & Revenue

If you have any questions regarding this balance, please do not hesitate to call our customer service department for assistance at (803) 791-2300 or toll free (877) 835-0975. If you have made this payment within the last five (5) days, please disregard this request.

Sincerely,

Customer Service
Patient Financial Services
Lexington Medical Center

10237-P555*TZP09G54V000364

LEXINGTON
MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, SC 29169
803-791-2000

RETURN SERVICE REQUESTED

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

IF PAYING BY MASTERCARD, VISA, CHECK OR MONEY ORDER, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT		
☐ MASTERCARD ☐ VISA		☐ CHECK / MONEY ORDER
CARD NUMBER		SIGNATURE CODE
SIGNATURE		EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
01/12/07	$60.00	H00024606477
	SHOW AMOUNT PAID HERE $	

612589A

)101

ADDRESSEE:
RICHARD A COOK
121 WILLMA ANN DR
LEXINGTON, SC 29073-9307

10237-P555

REMIT TO:
LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

0H00024606477000000060007273

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS

Lexington Radiology Associates, P.A.
PO Box 835
Oaks, PA 19456

FOR BILLING QUESTIONS,
PLEASE CALL 803-772-1778
Fax: 803-772-4031
Office Hours: 9AM - 4PM Mon. - Fri.

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ MASTERCARD ☐ VISA ☐ AMER. EXP. ☐ DISCOVER

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
04-26-07	$41.00	28298883

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

4382-320

RICHARD A COOK
121 WILMA ANN DR
LEXINGTON SC 29073-9307

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

Lexington Radiology Associates, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608

Patient: RICHARD A COOK

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

atient: RICHARD A COOK
ccount No: 28298883
Referring Physician HALL THOMAS R
Services Were Provided at: LEXINGTON MEDICAL CENTER

DATE	PROC CODE	DIAGNOSIS	UNITS	DESCRIPTION OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
3-31-07	71020	511.9	1	Chest, Two Views	41.00			41.00

Se habla espanol 866-729-7008

Current	31-60 Days	61-90 Days	Over 90 Days
$41.00	$0.00	$0.00	$0.00

PAYMENT DUE: 5/10/07

PATIENT BALANCE DUE : $41.00

you have insurance please contact our office. You are sponsible for the amount indicated in PATIENT BALANCE JE.

LEXINGTON RADIOLOGY ASSOCIATES, P.A.
P. O. BOX 7608
COLUMBIA SC 29202-7608
803-772-1778
Tax ID: 57-0561785

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

320

P.O. Box 876
Greenville, NC 27835-0876

May 1, 2007

RETURN SERVICE REQUESTED

1623779-200
RICHARD COOK
PO BOX 84783
LEXINGTON SC 29073-0014

SCA COLLECTIONS - GREENVILLE, N.C., INC
300 East Arlington Boulevard
Parliament Place, Suite 6-A, Greenville, NC 27858
Phone: 252-355-5500 / Toll Free: 800-334-7713

Creditor:	PROFESSIONAL PATHOLOGY SERVICE
Client Account #:	0007431212
Patient Name:	COOK RICHARD
List Date:	04/10/07
Balance:	$661.00

SCA COLLECTIONS, INC.
P.O. Box 876
Greenville, NC 27835-0876

THIS ACCOUNT HAS BEEN PLACED WITH THIS OFFICE FOR COLLECTION AND IT CALLS FOR PAYMENT IN FULL. THIS PAYMENT IN FULL MUST BE RECEIVED OR THIS ACCOUNT MAY BE PLACED ON YOUR CREDIT FILE AND MAY IMPAIR YOUR CREDIT STANDING. IF YOU HAVE A VALID REASON FOR NOT PAYING IN FULL, PLEASE CONTACT US BY TELEPHONE. DO NOT LET YOUR CREDIT SUFFER.....MAIL YOUR PAYMENT IN FULL TO OUR OFFICE.

UNLESS YOU NOTIFY THIS OFFICE WITHIN 30 DAYS AFTER RECEIVING THIS NOTICE THAT YOU DISPUTE THE VALIDITY OF THIS DEBT OR ANY PORTION THEREOF, THIS OFFICE WILL ASSUME THIS DEBT IS VALID.

IF YOU NOTIFY THIS OFFICE IN WRITING WITHIN 30 DAYS FROM RECEIVING THIS NOTICE, THIS OFFICE WILL: OBTAIN VERIFICATION OF THIS DEBT OR OBTAIN A COPY OF A JUDGMENT AND MAIL YOU A COPY OF SUCH JUDGMENT OR VERIFICATION.

IF YOU REQUEST THIS OFFICE IN WRITING WITHIN 30 DAYS AFTER RECEIVING THIS NOTICE, THIS OFFICE WILL PROVIDE YOU WITH THE NAME AND ADDRESS OF THE ORIGINAL CREDITOR, IF DIFFERENT FROM THE CURRENT CREDITOR.

THIS IS AN ATTEMPT TO COLLECT A DEBT, AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

SINCERELY,
SCA COLLECTIONS, INC.

Detach Below & Return Bottom Portion With Your Payment

Patient Name: COOK RICHARD	
Creditor : PROFESSIONAL PATHOLOGY SERVICES PC	
Balance: $661.00	Client Acct #: 0007431212
IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW	
☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP DATE
SIGNATURE	AMOUNT

Remit To:
SCA COLLECTIONS, INC.
P.O. Box 876
Greenville, NC 27835-0876

Creditor:	PROFESSIONAL PATHOLOGY SERVICE
Account #:	1623779
Patient Name:	COOK RICHARD
List Date:	04/10/07
Balance:	$661.00

SCG200-0501R300079-JVS1-3 239

LEXINGTON COUNTY EMS
5005 SUNSET BLVD.
LEXINGTON, SC 29072

RETURN SERVICE REQUESTED

'101

PAST DUE

PAGE: 1 of 1

ADDRESSEE:

COOK, RICHARD
121 WILMA ANN DR
LEXINGTON, SC 29073-9307

☐ Please check if above address is incorrect and indicate change on reverse side.

You may use our secure web site to pay by Credit Card: www.emsbillingsc.com — PIN # 2780

CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA

CARD NUMBER		SIGNATURE CODE
SIGNATURE		EXP. DATE

DATE	ACCOUNT NUMBER	PAYMENT
10/23/2006	671803	

PATIENT NAME	AMOUNT DUE:
COOK, RICHARD	$425.00

MAKE CHECK PAYABLE / REMIT TO: 651941A

LEXINGTON COUNTY EMS
5005 SUNSET BLVD.
LEXINGTON, SC 29072

13315-G521*1XE0IYUDG000923

PLEASE WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK OR MONEY ORDER.

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

PATIENT ACCOUNT STATEMENT

STATEMENT DATE	PATIENT ACCOUNT NO	PATIENT NAME
10/23/2006	671803	COOK, RICHARD

SERVICE DATE	RUN NO	DESCRIPTION	UNITS	ERROR DATE	CHARGES	PAYMENT / ADJ	PATIENT DUE
07/01/06	0611021	Previous Balance Due ..					425.00

SIGNATURE REQUIRED ON BACK OF STUB FOR INSURANCE PURPOSES

****THIS STATEMENT CANNOT BE USED TO FILE MEDICARE****

PAST DUE

EAR SIR / MADAM:

THE ABOVE LISTED ACCOUNT IS NOW PAST DUE. IT IS IMPORTANT THAT OU CONTACT OUR OFFICE TO MAKE ARRANGEMENTS TO SETTLE THIS MATTER. WE 'ILL WORK WITH YOU IF YOU CAN ONLY MAKE PARTIAL, REGULAR PAYMENTS.
IF YOU ARE COVERED BY INSURANCE, PLEASE FILL OUT THE REVERSE SIDE ND SEND BACK TO OUR OFFICE.
IF WE DO NOT HEAR FROM YOU WITHIN 10 DAYS, WE WILL BE FORCED TO ROCEED WITH ALTERNATIVE COLLECTION EFFORTS.

YOUR PROMPT ATTENTION TO THIS MATTER IS APPRECIATED.

TOTAL AMOUNT	$425.00
SERVICES RENDERED BY:	LEXINGTON COUNTY EMS
TAX I.D. #	576000379

TOLL-FREE PHONE: (800) 533-3915
LOCAL: (803)957-7111
HOURS: 8:00AM-5:00PM
MONDAY THRU FRIDAY

13315-G521*1XE0IYUDG000923

1XE00549N:1.1

YOUR STATEMENT

Our records indicate the balance is your responsibility. Please pay the balance in full or contact Customer Service if you have any questions regarding this bill.

SUMMARY OF CHARGES

255 PHARMACY INCID TO RAD	302.00
270 M/S SUPPLY GENERAL	69.00
301 LABORATORY CHEMISTRY	317.00
305 LAB HEMATOLOGY	382.00
320 RADIOLOGY DIAG GENERAL	366.00
350 CAT SCAN GENERAL	1832.00
450 EMERGENCY ROOM GENERAL	556.00
730 EKG/ECG GENERAL	237.00
981 PROF FEES EMERGENCY ROOM	733.00
985 PROF FEES EKG	65.00
Billed charges to date:	4859.00

INSURANCE INFORMATION

10237-P555

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2300 OR (877) 835-0975, MONDAY-FRIDAY, 8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	05/01/07
Patient Name:	RICHARD A COOK
Date of Service:	03/31/07
Account Number:	H00028298883
Total Charges:	4859.00
Insurance Payments Received:	0.00
Adjustments to Insurance:	0.00
Patient Payments Received:	0.00

PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

This is your balance: 4859.00

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER | SIGNATURE CODE

SIGNATURE | EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
05/16/2007	05/01/07	H00028298883

AMOUNT DUE	
4859.00	SHOW AMOUNT PAID HERE $

PAGE: 1 of 1

0101

ADDRESSEE:

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

651741B

OH00028298883000004859007273

10237-P555*T2Q0B3EWP000419

Professional
HOSPITAL SERVICES
Palmetto Health

May 07, 2007

R0706401659
RICHARD ASHFORD COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

Patient Name: RICHARD COOK
PALMETTO HEALTH RICHLAND
Account #: R0706401659
Current Balance: $765.00
DATE OF SERVICE: 03/05/2007

Dear RICHARD ASHFORD COOK:

This account remains outstanding with Palmetto Health. If your account is not resolved within 20 days of the date of this letter, it will be considered for further collection activity, which may include placement with an outside collection agency.

If you wish to stop this action, please contact us immediately at (803) 296-7900 or 1-800-499-5962 to complete a payment arrangement. If you have already sent in your payment, please disregard this notice.

NOTE: Palmetto Health offers Financial Assistance to our uninsured and under insured patients that meet certain guidelines.

Thank you.

J. Ross (PHS)
PATIENT REPRESENTATIVE
(803) 296-7924
BD75

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

MAKE CHECKS PAYABLE TO:

Professional
HOSPITAL SERVICES
Palmetto Health

293 GREYSTONE BLVD.
FIRST FLOOR
COLUMBIA, SC 29210

RETURN SERVICE REQUESTED

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT
☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
05/07/07	$765.00	R0706401659

SHOW AMOUNT PAID HERE $

612528A

0101

RICHARD ASHFORD COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

15970-U631

PROFESSIONAL HOSPITAL SERVICES
PO BOX 402111
ATLANTA, GA 30384-2111

15970-U631*T2W17PNFT002921

2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169

ADDRESS SERVICE REQUESTED

V18126 37
B5392M
SA14
BNS 003
2413 R

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169-4839

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
803-939-8989	04/13/07	1451449	1	77.00	$

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
11107	LIBBEY MD	ESTAB PATIENT EXAM -LEVEL CALLED MCAID VRU, PT NOT ELIGIBLE FOR MCAID ON THI DOS	RICHARD	77.00		

Insurance Balance: 0.00

Patient Balance: 77.00

ement 04/13/07

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 1451449

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
77.00	0.00	0.00	0.00	77.00	0.00	77.00

INQUIRIES / PAYMENTS TO
SOUTHERN SURGICAL GROUP
2728 SUNSET BLVD STE 403
WEST COLUMBIA, SC 29169
803-939-8989

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

YOUR STATEMENT

Thank you for allowing us to serve your healthcare needs.Our records indicate no insurance coverage for this bill and the balance is your responsibility. Please pay the balance in full by the date shown or contact Customer Serivce.

10237-P555

SUMMARY OF CHARGES

255 PHARMACY INCID TO RAD	302.00
270 M/S SUPPLY GENERAL	69.00
301 LABORATORY CHEMISTRY	317.00
305 LAB HEMATOLOGY	382.00
320 RADIOLOGY DIAG GENERAL	366.00
350 CAT SCAN GENERAL	1832.00
450 EMERGENCY ROOM GENERAL	556.00
730 EKG/ECG GENERAL	237.00
981 PROF FEES EMERGENCY ROOM	733.00
985 PROF FEES EKG	65.00
Billed charges to date:	4859.00

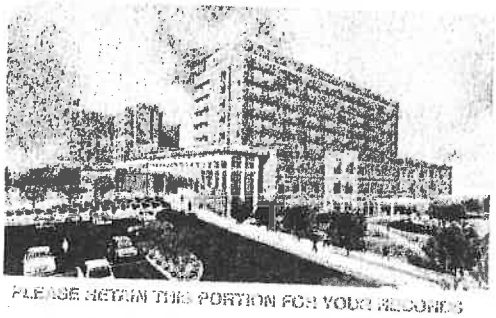
INSURANCE INFORMATION

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2300 OR (877) 835-0975, MONDAY-FRIDAY, 8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	04/06/07
Patient Name:	RICHARD A COOK
Date of Service:	03/31/07
Account Number:	H00028298883
Total Charges:	4859.00
Insurance Payments Received:	0.00
Adjustments to Insurance:	0.00
Patient Payments Received:	0.00



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

This is your balance: 4859.00

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER | SIGNATURE CODE

SIGNATURE | EXP. DATE

PAGE:	STATEMENT DATE	ACCT. #
04/21/2007	04/06/07	H00028298883

AMOUNT DUE	SHOW AMOUNT PAID HERE
4859.00	$

PAGE: 1 of 1

6517418

0101

ADDRESSEE:

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

DH0002829888300000485900727 3

10237-P555*T210LQF5C000420

Medical Collection Services of LMC

DEAR RICHARD A COOK:

```
* * * * * * * * * * *
*                   *
*    FINAL NOTICE   *
*                   *
* * * * * * * * * * *
```

YOUR ACCOUNT IS PAST DUE 120 DAYS. WE ARE PREPARING YOUR ACCOUNT FOR THE CREDIT BUREAU AND/OR SOUTH CAROLINA TAX PROGRAM.

IF THIS ACCOUNT IS PLACED IN THE TAX PROGRAM, THE SOUTH CAROLINA DEPARTMENT OF REVENUE WILL GARNISH YOUR INDIVIDUAL INCOME TAX REFUND(S) UNTIL THE DEBT IS PAID IN FULL. ALL ACCOUNTS REPORTED TO THE CREDIT BUREAU WILL REMAIN ON YOUR NATIONAL CREDIT HISTORY FOR A PERIOD OF SEVEN (7) YEARS.

PAYMENT IN FULL IS DUE IMMEDIATELY. IF YOU HAVE ANY QUESTIONS REGARDING YOUR ACCOUNT YOU MAY REACH US AT (803) 791-2100, OR EMAIL US AT MCS@LEXHEALTH.ORG.

IF PAYMENT HAS BEEN SUBMITTED WITHIN SEVEN (7) DAYS PLEASE DISREGARD THIS NOTICE.

THIS IS AN ATTEMPT TO COLLECT A DEBT, ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

SINCERELY,

MEDICAL COLLECTION SERVICES OF LMC

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT

P.O. Box 100274
Columbia, SC 29202-3274

17196-Q951

April 10, 2007

PAGE NO. 1 of 1

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW.	
CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA	
CARD NUMBER	V-CODE
SIGNATURE	EXP. DATE
PATIENT NAME: RICHARD A COOK	ACCT. #: H24606477
BALANCE DUE: $60.00	SHOW AMOUNT PAID HERE: $

632410B

0101

ADDRESSEE:

RICHARD A COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

REMIT TO:

MEDICAL COLLECTION SERVICES OF LMC
P.O. BOX 100274
COLUMBIA, SC 29202-3274

0000H24606477000000060008274

17196-Q951*T2511V5E6003094

PALMETTO HEALTH RICHLAND

P.O. BOX 402130
ATLANTA, GA 30384-2130

15970-U630

0101

STATEMENT DATE April 04, 2007

PAGE: 1 of 1

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

PATIENT NAME AND ACCOUNT#	DATES OF SERVICE
RICHARD COOK R0708500479	03/26/2007 - 03/26/2007

ACCOUNT BALANCE	TOTAL CHARGES	AMOUNT PAID
$9,184.00	$9,184.00	$

652527B

[redacted] ADDRESSEE: [redacted]

RICHARD ASHFORD COOK
PO BOX 84783
LEXINGTON, SC 29073-0014

[redacted] REMIT TO: [redacted]

PALMETTO HEALTH RICHLAND
PO BOX 402111
ATLANTA, GA 30384-2111

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

15970-U630*T1Z166CVD000252

PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT AND WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

ACCOUNT NUMBER	PATIENT NAME	ADMIT DATE	DISCH. DATE	TYPE	FC
R0708500479	RICHARD COOK	03/26/2007	03/26/2007		

Dear: RICHARD ASHFORD COOK,

Thank you for choosing Palmetto Health RICHLAND as your health care provider. No insurance was provided at the time of service for this visit; therefore, this bill represents the balance due.

Please send payment in full for the balance shown on the statement or contact our office for other arrangements.

Palmetto Health offers financial assistance to the underinsured or uninsured.

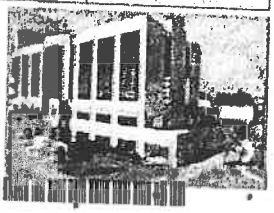
Patient Financial Services Department
296-5098 or call toll free 1-800-243-7711

YOU WILL RECEIVE A SEPARATE BILL FOR PHYSICIAN SERVICES

PREVIOUS BALANCE	ADJUSTMENTS	INSURANCE PAYMENTS	PATIENT PAYMENTS	ACCOUNT BALANCE	ESTIMATED INS. LIABILITY	PATIENT RESPONSIBILITY	PLEASE PAY THIS AMOUNT	
								$9,184.00

Note: Amounts indicated to be paid by third parties are estimated by the hospital. However, the patient and / or responsible party have personally guaranteed payment and are responsible for the total charges on this statement.

PALMETTO HEALTH RICHLAND



COOK, RICHARD

Medical Record Number M001040773

Account Number H00028298883

Date 3/31/2007

Lexington Medical Center
Emergency Department

Discharge Instructions

Discharge Date/Time 3/31/2007 7:05:00 PM

Diagnoses

SOB

Near Syncope

COLON CANCER

You have been evaluated today by an independent healthcare provider practicing Emergency Medicine. In most cases follow-up care is recommended with your regular Doctor, HMO or Clinic.

Within 2 days ☐ Doctor ☐ HMO ☐ Clinic

Call for appointment as soon as possible. IDENTIFY yourself as an ER Patient. If you don't have a doctor or need a specialist follow up with:

Physician/Specialist **SC Heart Center - West Columbia**

Address **SC Heart Center - West Columbia 2728 Sunset Bl**

Phone **(803) 794 - 3950**

Additional Instructions:

If the symptoms worsen or new symptoms develop return to the Emergency Department (ED) immediately.
Call your doctor for additional questions.
ED phone number: 803-936-8128

DRINK EXTRA FLUIDS. AVOID STANDING UP TOO FAST OR TOO LONG.

SEE SCHC THIS WEEK FOR FURTHER EVAL OF CHEST PAIN.

Additional instructions were given on the following conditions:

- ☐ Abdominal Pain
- ☐ Allergic Reaction
- ☐ Asthma
- ☐ Back Pain
- ☐ Chest Pain
- ☐ Conjunctivitis
- ☐ Corneal Abrasion/Eye Injury
- ☐ Fever
- ☐ Fracture/Sprain/Strain
- ☐ Head Injury
- ☐ High Blood Pressure
- ☐ Kidney Stone
- ☐ Neck Strain
- ☐ Nose Bleed
- ☐ Middle Ear Infection
- ☐ PID/STD
- ☐ Sore Throat/Pharyngitis
- ☐ Threatened Abortion
- ☐ Toothache
- ☐ Upper Respiratory Infection
- ☐ UTI/Kidney Infection
- ☐ Vaginal Bleeding
- ☐ Vomiting/Diarrhea
- ☐ Wound Care/Sutures

Other:

Work/School Restriction:

☐ You may return to work/school today.

You may not return to work/school until:

This information may be released to my school or employer

☐ If you had x-rays or blood tests, please note that these don't always show what's wrong. Sometimes x-rays don't show broken bones. After review by a specialist you will be notified if there is an abnormality.

☐ You may not drive or operate heavy machinery because the medicines you have may make you sleepy.

Physician (Print)
Hall, Thomas MD (TH)

Nurse Signature: X

Patient Signature: X

COOK, RICHARD, Wed Aug 09 11:18:09 EDT 2006

South Carolina Oncology Associates
Columbia, SC

Patient Information:

Patient ID: 615020
Patient Name: COOK, RICHARD
Birth Date: 1962.12.09

Exam Information:

Accession Number: 84266
Procedure Code: 84266
Procedure Description: PET/CT (SUB TOTAL)
Scheduled Date: 2006.08.09
Requesting Physician: UNKNOWN
Reason for Exam: COLON CA

Report Information:

Dictated By:
Transcribed By:
Approving Physician: 34, Friedman Sam
Approval Date: 2006.08.10
Approval Time: 16:45:00.0000

Radiological Report :

***** FINAL REPORT *****

ORDERING PHYSICIAN: CHRISTIANSEN, NEAL P. M.D.

PROCEDURE: PET/CT (SUB TOTAL)
ACCESSION #: 84266

INDICATION: Colon cancer.

No previous studies.

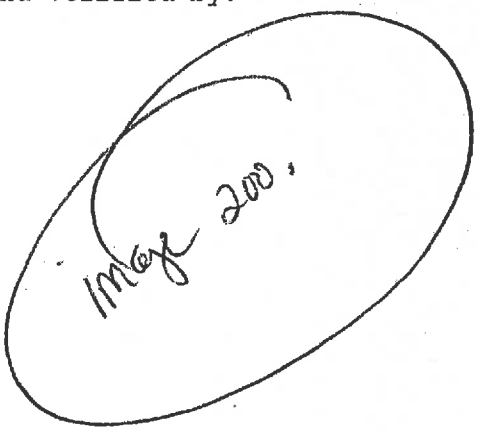
Initially, noncontrast low dose helical CT scan is performed for attenuation

correction and localization purposes. Dilute oral contrast was given. This is followed by PET scanning with IV administration of 15.65 mCi of F-18 FDG without incident.

We see the expected hypermetabolic activity in the brain, heart, renal collecting systems, bladder and also bowel and liver. There is increased activity at a left mid abdominal ostomy site, and also in what appears to be a midline abdominal wall incision. There is the expected bowel activity mainly in the colon. There is however one suspicious focus noted within the left hemipelvis anterolaterally. This shows intense hypermetabolic activity with SUV of 9.2 maximum and average 5.6. It corresponds to an ill-defined soft tissue density measuring about 24 mm in greatest diameter. While conceivably this could represent post-op change it must be considered suspicious for metastatic disease and biopsy is recommended for further evaluation. There is no other abnormal uptake demonstrated.

IMPRESSION: Solitary abnormality involving a focus of uptake within a small soft tissue nodule in the left hemipelvis. This is suspicious for metastatic disease and biopsy should be considered. There are post-op changes as described.

This document has been electronically signed and verified by:
Sam Friedman, MD on: 08/10/2006 16:45:11



sf/cba/256456
08/09/2006 12:31:20/08/10/2006 10:24:55
Pitts Radiology

xc
PITTS RADIOLOGY

??

??

??

??

THIS REPORT WAS RECEIVED FROM AN EXTERNAL RIS SYSTEM

LCA COLLECTIONS

A Division of Laboratory Corporation of America

PAST DUE

TAX ID# : 13-3757370
626314800550

#BWNDJPN * * * 5-DIGIT 29073
#004760231201#
RICHARD COOK
121 WILMA ANN DR
LEXINGTON, SC 29073-9307

PATIENT: RICHARD COOK
INVOICE DATE: 01/23/07

YOUR INVOICE # : FACTURA :	47602312
AMOUNT DUE:	$64.00

DATE OF SERVICE: 09/20/06
TEST REQUESTED BY: SOUTH CAROLINA ONCOLOGY ASSOC

Your Immediate Payment Required

LabCorp provided you professional diagnostic services that remain unpaid. Our records indicate that your account still remains outstanding.

We have sent you several statements regarding this outstanding payment obligation. Regretfully, unless this office receives payment in full, escalated recovery steps will be taken. Be advised, this office reserves the right to report unpaid debt(s) to a credit bureau(s).

This is a serious matter you should no longer ignore. You must act now to clear your delinquent credit status. There is no longer any justification for not resolving your account. Call 1-800-845-6167 immediately to resolve this account.

Act immediately.

IMPORTANTE: Su cuenta esta vencida. Tenemos agentes bilingues disponibles para asistirle. Llamenos ahora para resolver su situacion.

** CALL BETWEEN 8:00AM - 5:00PM MON-FRI, EASTERN TIME ** 1-800-845-6167

FOR PROPER CREDIT, RETURN THIS PORTION WITH YOUR PAYMENT

121 WILMA ANN DR
LEXINGTON, SC 29073-9307

PLEASE DO NOT SEND CASH

FOR: RICHARD COOK

MAKE CHECK OR MONEY ORDER PAYABLE TO:

LCA
P.O. BOX 2240
BURLINGTON, NORTH CAROLINA 27216-2240

TERMS PAYABLE ON RECEIPT

YOUR INVOICE NO.
47602312
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Case Notes ID	Entry Date	Last Update	Last Update User	Notes
1355	9/18/2007	9/18/2007	LYNCHJEN	Note from Jan to call Congressman Wilson's office and le
1216	9/11/2007	9/11/2007	CAULEY	Reviewed, determine that this is a repeat of an item rece
1212	9/11/2007	9/11/2007	LYNCHJEN	A new log came in, but it's from Joe Wilson again. Same

EDIT

Case Notes ID: 1355

Constituent Data

Constituent ID: 854
SSN: 255945433
MEDICAID: 000000000000
First Name: Richard
Middle Initial: A
Last Name: Cook
Legislator / Other: Congressman Wilson

Notes

Note from Jan to call Congressman Wilson's office and let them know we received duplicate letter. I was told to fax our orignal response to Ms. Coefield's attention.

No mailed response letter is necessary. I faxed our original letter dated 8/23/07 on 9/18.
LYNCHJEN 9/18/2007 9:56:03 AM

Staff Data

Staff ID: 2
Jennifer Dabbs

Spell Check
Grammar Check
Print this Form

Entry Date: 9/18/2007
Last Update: 9/18/2007
Last Update User: LYNCHJEN

Record : 1 / 10

FAX COVER SHEET

"CONFIDENTIAL INFORMATION ENCLOSED"

DATE: 9/18/07

TO: Ms. Coefield
Telephone #: _____
Fax #: 803-939-0078

FROM: Jennifer Dabbs

Total Number of Pages Transmitted: 2 (Including Cover Sheet)

COMMENTS:
Here is a copy of our original response letter.
Thanks!

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this in error, please notify us immediately and destroy the related message. Thank you.

Bureau of Eligibility Policy and Oversight
P.O. Box 8206 • Columbia, South Carolina 29202-8206
Phone (803) 898-2635 • Fax (803) 255-8350

TRANSACTION REPORT

Transmission
Transaction(s) completed

NO.	TX DATE/TIME	DESTINATION	DURATION	PGS.	RESULT	MODE
32	SEP. 18 09:09	12022525455	0' 00' 47"	002	OK	Normal

SEP. 18' 07 (TUE) 09:10 CLTC SUMTER TEL:803 905 1987 P.001

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

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State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

August 23, 2007

The Honorable Joe Wilson
United States House of Representatives
Midlands District Office
1700 Sunset Blvd.
West Columbia, South Carolina 29169

Dear Congressman Wilson:

Thank you for referring Mr. Richard A. Cook to our agency for assistance with his healthcare needs and living expenses.

A member of our staff has been in direct contact with Mr. Cook regarding Medicaid eligibility and the rules and regulations governing the program. We provided Mr. Cook with information on other programs and organizations that can assist residents in South Carolina with their healthcare services, prescription medications, inpatient hospitalization and daily living needs.

Thank you for your continued interest and support of the South Carolina Medicaid program. If I may be of further assistance on this or any other matter, please let me know.

Sincerely,

Emma Forkner
Director

EF/jcod

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
Phone (803) 898-2504 • Fax (803) 255-8235