Instructions for Student

An eligible educational institution, such as a college or university in which you are enrolled, and an insurer who makes reimbursements or refunds of qualified tuition and related expenses to you must furnish this statement to you. You, or the person who can claim you as a dependent, may be able to claim an education credit on Form 1040 or 1040A for the qualified tuition and related expenses that were actually paid in 2009. Institutions may report either payments received in box 1 or amounts billed in box 2. The amount shown in box 1 or 2 may represent an amount other than the amount actually paid in 2009. Your institution must include its name, address, and information contact telephone number on this statement. It may also include contact information for a service provider. Although the service provider may be able to answer certain questions about the statement, do not contact them or the filer for explanations of the requirements for (and how to figure) any education credit that you may claim. For more information about the credit, see Pub. 970, Tax Benefits for Education, Form 8863, Education Credits, and the Form 1040 or 1040A instructions.

Account number. May show an account or other unique number the filer assigned to distinguish your account.

Box 1. Shows the total payments received from any source for qualified tuition and related expenses less any related reimbursements or refunds.

Box 2. Shows the total amounts billed for qualified tuition and related expenses less any related reductions in charges.

Box 3. Shows whether your institution changed its method of reporting for 2009. It has changed its method of reporting if the method (payments received or amounts billed) used for 2009 is different than the reporting method used for 2008. You should be aware of this change in figuring your education credits. The credits are allowable only for amounts actually paid during the year and not amounts reported as billed, but not paid, during the year.

Box 4. Shows any adjustment made for a prior year for qualified tuition and related expenses that were reported on a prior year Form 1098-T. This amount may reduce any allowable education credit that you claimed for the prior year. See "recapture" in the index to Pub. 970 to report a reduction in your education credit or tuition and fees deduction.

Box 5. Shows the total of all scholarships or grants administered and processed by the eligible educational institution. The amount of scholarships or grants for the calendar year (including those not reported by the institution) may reduce the amount of the education credit you claim for the year.

Box 6. Shows adjustments to scholarships or grants for a prior year. This amount may affect the amount of any allowable tuition and fees deduction or education credit that you claimed for the prior year. You may have to file an amended income tax return (FORM 1040X) for the prior year.

Box 7. Shows whether the amount in box 1 or 2 includes amounts for an academic period beginning January-March 2010. See Pub. 970 for how to report these amounts.

Box 8. Shows whether you are considered to be carrying at least one-half the normal full-time workload for your course of study at the reporting institution. If you are at least a half-time student for at least one academic period that begins during the year, you meet one of the requirements for the Hope credit. You do not have to meet the workload requirement to qualify for the lifetime learning credit.

Box 9. Shows whether you are considered to be enrolled in a program leading to a graduate degree, graduate-level certificate, or other recognized graduate-level educational credential. If you are enrolled in a graduate program, you are not eligible for the Hope credit, but you may qualify for the lifetime learning credit.

Box 10. Shows the total amount of reimbursements or refunds of qualified tuition and related expenses made by an insurer. The amount of reimbursements or refunds for the calendar year may reduce the amount of any education credit you can claim for the year.

OMB No. 1545-1574

FILER'S name, street address, city, state, ZIP code, and telephone number
KEISER UNIVERSITY
1900 W COMMERCIAL BLVD
FORT LAUDERDALE FL 33309
[redacted]

1 Payments received for qualified tuition and related expenses: $ 7263.00

2 Amounts billed for qualified tuition and related expenses: $

CORRECTED (if checked) ▶ ☐

2009 Form 1098-T — Tuition Statement

3 If this box is checked, your educational institution has changed its reporting method for 2009 ☐

Copy B For Student

FILER'S federal identification no. [redacted]

STUDENT'S social security number [redacted]

4 Adjustments made for a prior year: $

5 Scholarships or grants: $ 2381.00

STUDENT'S name, street address (including apt. no.) city, state, and ZIP code
JANELLE GEDMIN
7618 W SAINT FRANCIS ROAD
FRANKFORT IL 60423

6 Adjustments to scholarships or grants for a prior year: $

7 Checked if the amount in box 1 or 2 includes amounts for an academic period beginning January - March 2010 ▶ ☐

This is important tax information and is being furnished to the Internal Revenue Service.

Service Provider/Acct. No. (see instr.) [redacted]

8 Checked if at least half-time student ☒

9 Checked if a graduate student ☐

10 Ins. contract reimb./refund: $

Form 1098-T (keep for your records)

Department of the Treasury - Internal Revenue Service

Keiser University

KEISER UNIVERSITY

July 25, 2010

Account Information

Janelle Gedmin

Select Enrollment 8/30/2009 Associates of Science in Medical Assisting

Your balance for the selected enrollment is **($290.06)**

Pay Now

Account Details **Payment Schedule** **Make a Payment** **My Statements** **Registration Bill**

Registration Bill Summary by Term

Student's Registration Bill

NOTE: Adobe Acrobat Reader is required to view your online PDF documents. You can download the most recent version of the free software. Get Acrobat Reader now.

Term 2009 Fall A Semester **Amount due or (due to Student) = ($220.00)**

Description **Amount**

Account Summary:

Charges	$7,088.00
Financial Aid	$0.00
Payments	$7,308.00

Account Details:

Charges

Tuition	$6,688.00
Educational Fees	$400.00
Total:	**$7,088.00**

Financial Aid

Total:	**$0.00**

Payments

		Date
Payment on Account	$50.00	2/4/2010
Payment on Account	$50.00	1/4/2010
Scholarship - Financial 2009-10	$631.00	12/7/2009
Student Payment 2009-10	$50.00	12/2/2009
Direct Sub Loan 2009-10	$1,742.00	11/23/2009
Direct Unsub Loan 2009-10	$1,990.00	11/23/2009
Direct Unsub Overage 2009-10	$995.00	11/23/2009
Pell Grant 2009-10	$1,750.00	11/23/2009
Student Payment 2009-10	$50.00	11/13/2009
Total:	**$7,308.00**	

KEISER UNIVERSITY

July 25, 2010

Account Information

Janelle Gedmin

Select Enrollment 8/30/2009 Associates of Science in Medical Assisting

Your balance for the selected enrollment is **($290.06)**

Pay Now

Registration Bill Summary by Term

Student's Registration Bill

NOTE: Adobe Acrobat Reader is required to view your online PDF documents. You can download the most recent version of the free software. Get Acrobat Reader now.

Term 2010 Winter A Semester **Amount due or (due to Student) = ($802.61)**

Description	Amount
Account Summary:	
Charges	$7,088.00
Financial Aid	$0.00
Payments	$7,890.61

Account Details:

Charges

Tuition	$6,688.00
Educational Fees	$400.00
Total:	**$7,088.00**

Financial Aid

Total:	**$0.00**

Payments

		Date
Refund - SFIN 2009-10	($312.39)	5/4/2010
Direct Sub Loan 2009-10	$498.00	4/20/2010
Direct Sub Loan 2009-10	$498.00	4/20/2010
Payment on Account	$50.00	4/5/2010
Payment on Account	$50.00	2/24/2010
Scholarship - Financial 2009-10	$630.00	1/5/2010
Direct Sub Loan 2009-10	$1,742.00	1/4/2010
Direct Unsub Loan 2009-10	$1,990.00	1/4/2010
Direct Unsub Overage 2009-10	$995.00	1/4/2010
Pell Grant 2009-10	$1,750.00	1/4/2010
Total:	**$7,890.61**	

KEISER UNIVERSITY

Academics
My Profile
My Finances
Account Information
Make Payment Online
Payment Information
My Financial Aid
My Documents

Account Information

Print Page
Email My Advisor

Janelle Gedmin

Select Enrollment 8/30/2009 Associates of Science in Medical Assisting

Your balance for the selected enrollment is **($290.06)**

Pay Now

Account Details **Payment Schedule** **Make a Payment** **My Statements** **Registration Bill**

Registration Bill Summary by Term

Student's Registration Bill

NOTE: Adobe Acrobat Reader is required to view your online PDF documents. You can download the most recent version of the free software. Get Acrobat Reader now.

Term 2010 Summer A Semester **Amount due or (due to Student) = ($300.00)**

Description	Amount
Account Summary:	
Charges	$5,316.00
Financial Aid	$0.00
Payments	$5,616.00

Account Details:

Charges		
Tuition	$5,016.00	
Educational Fees	$300.00	
Total:	**$5,316.00**	

Financial Aid		
Total:	**$0.00**	

Payments		Date
Direct Sub Loan 2009-10	$886.00	6/14/2010
Direct Unsub Loan 2009-10	$788.00	6/14/2010
Direct Unsub Overage 2009-10	$395.00	6/14/2010
Scholarship - Financial 2009-10	$163.00	5/5/2010
Direct Sub Loan 2009-10	$887.00	4/28/2010
Direct Unsub Loan 2009-10	$789.00	4/28/2010
Direct Unsub Overage 2009-10	$395.00	4/28/2010
Pell Grant 2009-10	$1,313.00	4/26/2010
Total:	**$5,616.00**	

DIRECT ALL CORRESPONDENCE TO:
CENGAGE Learning
P.O. Box 6904
Florence, KY 41022-6904

Phone: 1-800-354-9706

1 800-487-8488

ORIGINAL INVOICE

NO. 88680680

DATE 09/03/09

PAGE 1 OF 1

Document type: SE

Parcel: 70519771

SHOWING ACCOUNT NUMBER AND INVOICE NUMBER SAN: 2002213

Federal ID No.: [redacted] Canadian G.S.T.#/T.P.S.: 14074 8831 RT0001 Canadian Q.S.T.#/T.V.Q.: 1023272543

ACCOUNT NO. 11928850
SAN

ACCOUNT NO. 11928850
SAN

BILL TO
JANELLE GEDMIN
7618 W SAINT FRANCIS ROAD
FRANKFORT IL 60423

SHIP TO
JANELLE GEDMIN
7618 W SAINT FRANCIS ROAD
FRANKFORT IL 60423

73910135SE

PURCHASE ORDER NUMBER	PAYMENT DUE	TERMS	FOB Shipping Point
GEDMINJ	10/03/09	Net 30 Days	UPSGNDRES

QUANTITY SHIPPED	QUANTITY PENDING	ISBN	TITLE,AUTHOR,EDITION	PRICE	DISCOUNT	NET AMOUNT
1		1418032670	WKBK-MEDICAL ASSISTING 6E KEIR/WISE/KREBS 06 ISBN-13: 9781418032678	77.95		77.95

1	BOOKS	SUBTOTAL	77.95
		SALES TAX 6.25	4.87
		TRANS & HDLG	6.20
		CC# - *****1318	-89.02
		PAY THIS AMOUNT	.00

RETURNS POLICY

Customers may return a defective or damaged product within thirty days of purchase with prior approval. Please forward your request to sales@cengage.com to obtain approval for your return.

DETACH: THIS PORTION MUST BE RETURNED WITH YOUR PAYMENT

PURCHASE ORDER NUMBER	INVOICE DATE	INVOICE NUMBER	CUSTOMER ACCOUNT NUMBER	PAYMENT DUE	AMOUNT DUE
GEDMINJ	09/03/09	88680680	11928850	10/03/09	.00

RETURN THIS STUB WITH PAYMENT TO:

MAIL CHECKS TO:
CENGAGE LEARNING
P.O. BOX 95999
CHICAGO, IL 60694-5999

WIRE TRANSFERS:
HARRIS BANK
ABA 071000288
ACCT 4399010
SWIFT HATRUS44

RETURN BOOKS TO:
CENGAGE Learning
Distribution Center
10650 Toebben Drive
Location 02
Independence, KY 41051

00637119288500188680680100000000?

ALL CLAIMS AND SHIPPING ERRORS MUST BE REPORTED WITHIN 90 DAYS AFTER DATE OF INVOICE

About the examination

The Certifying Board does not discriminate among applicants as to age, sex, race, religion or national origin. Membership in the American Association of Medical Assistants (AAMA) is not required. Policies of the AAMA Certifying Board and fees are subject to change without notice.

Certification credential

The CMA (AAMA) credential represents a medical assistant who has been credentialed through the Certifying Board of the American Association of Medical Assistants. The credential is awarded to candidates who pass the CMA (AAMA) Certification/Recertification Exam. The credential must be recertified every five years by continuing education or reexamination to give evidence of continuing competency and knowledge, and thus better protect patients. The CMA (AAMA) must have current status in order to use the credential in connection with employment.

Eligibility, documentation, and fees

Eligibility category	Required documentation	Fee (nonrefundable)
Category 1 Completing student or recent graduate of a CAAHEP or ABHES medical assisting program	No documentation required. Your program completion—including a practicum—must be verified by your program director in order for you to receive your official scores.	$125
Category 2 Nonrecent graduate of a CAAHEP or ABHES medical assisting program	Official transcript	$125 AAMA members $250 nonmembers
Category 3 CMA (AAMA) recertificant	Proof of current provider level CPR certification and photocopy of CMA (AAMA) certificate	$125 AAMA members $250 nonmembers

Request a receipt today

The Certification Program of the Certifying Board of the American Association of Medical Assistants is accredited by the National Commission for Certifying Agencies (NCCA) as a result of demonstrating compliance with the NCCA Standards for the Accreditation of Certification Programs. The NCCA is the accrediting body of the Institute for Credentialing Excellence (ICE), formerly called the National Organization for Competency Assurance (NOCA). The NCCA Standards were created to ensure that certification programs adhere to modern standards of practice for the certification industry.

Applicant agreement

By virtue of submitting an application for the CMA (AAMA) Certification/Recertification Examination, I certify what follows:

I understand and am in compliance with the eligibility requirements for the CMA (AAMA) Exam. I have not served as an AAMA Certifying Board or an AAMA Task Force for Test Construction member or as a chief or assistant proctor for the CMA (AAMA) Exam within the 23-month period prior to the date of the CMA (AAMA) Exam for which I am applying.

The information supplied in this application is true and accurate to the best of my knowledge. I acknowledge that the AAMA Certifying Board may refuse to accept this application and may decline to permit me to take the exam. Further, the AAMA Certifying Board may invalidate the scores on this exam if it receives evidence satisfactory to the AAMA that the statements made by me are not true and accurate or that I engaged in any inappropriate conduct before, during, or after the exam (such as giving or obtaining unauthorized information or aid).

I have read, understand, and will abide by the policies set forth in this *Candidate Application and Handbook*. I understand and consent to the fact that: (1) if I am in Eligibility Category 1, in order to be eligible to receive my scores, my program director must complete a form verifying my medical assisting program enrollment and that I completed no earlier than 30 days prior to the date that I took the exam all program requirements, including a practicum; (2) the information on this form and the exam results may be used for statistical and research purposes; (3) a list of applicants who pass the CMA (AAMA) Exam may be used by AAMA and state societies and local chapters for membership recruitment purposes; (4) the names and exam scores of initial certification candidates will be released to the officials of the medical assisting program from which each applicant graduated. *(Applicants who do not want their name sent to an AAMA state and local affiliate, their medical assisting program, or any other party must instruct the Certifying Board by certified mail, no later than 10 days before taking the exam, to withhold such scores. Requests received after this time will not be honored.)*

RPT (Registered Phlebotomy Technician) Exam Application

PART III. **APPROVED PHLEBOTOMY EXPERIENCE**

Approved phlebotomy experience credited toward certification must be earned in an approved health care facility that engages in the collection, examination, or transportation of materials derived from the human body. It may be:

(a) in a clinical laboratory (i) directed by a person holding an earned doctorate degree in one of the sciences, or (ii) approved, during the time of claimed credit, for service to patients under "Conditions for Coverage of Services of Independent Laboratories" under Medicare adopted by the Secretary of Health and Human Services (HHS, formerly HEW), as such conditions may exist from time to time, or (iii) in a state or city which licenses clinical laboratories, in a laboratory approved by the state or city, or

(b) in a research laboratory (i) operated by an accredited college or university, or (ii) directed by the holder of an earned doctorate degree, or

(c) in a laboratory of a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations or by the Bureau of Hospitals of the American Osteopathic Association, or

(d) in any other type of health care facility where such skills and experience may be acquired, such as a HMO, POL, Group Practice, etc.

Where required, phlebotomy experience will be verified by AMT with the facilities listed below:

Name of Lab and Director	Street Address/City/State/Zip	Dates of Employment (month & year)
Reem's Clinic & Institute of Medicine	7524 W. 103rd St. Bridgeview, IL 60455	From 1/10 To 3/10
		From ___/___ To ___/___
		From ___/___ To ___/___

PART IV. **RECOMMENDATION FOR CERTIFICATION**

In order for this application to be processed, it must be signed by either a physician or an AMT member in good standing.

☒ Physician Signature A Ramadan

☐ AMT Member Address 7524 W. 103rd St. Bridgeview IL

(If member) AMT Registry # .....

PART V. **OPTIONAL SCORE RELEASE**

Some educational institutions request their graduates' examination results. To grant permission for your results to be eligible for release if requested, sign the release authorization below. Signing this release is VOLUNTARY, and will not affect the outcome of your examination in any way. If you do NOT want your results released, DO NOT sign the authorization.

I hereby authorize American Medical Technologists to release my examination results to the school listed in II C above.

Janelle Gedmin
Signature of Examinee

PART VI. **AGREEMENT**

I consent to give AMT the authority to request the necessary information from individuals, institutions, and/or organizations named herein in order to validate credentials for certification. I certify that the statements made herein are true and correct, to my knowledge and belief, and realize that certification is subject to revocation for misrepresentation. If accepted as a certificant, I agree to uphold and abide by the Standards of Practice and Bylaws of the AMERICAN MEDICAL TECHNOLOGISTS.

ENCLOSED HEREWITH IS MY APPLICATION FEE OF SEVENTY-EIGHT DOLLARS ($78.00). ← $

Date 7-1-10 Signature Janelle Gedmin

***NOT REFUNDABLE. Applicant may take the examination two times on this application. A retake is permitted no sooner than three (3) months from the first attempt and no later than two (2) years after the date of the application. A retesting fee of $60.00 will be required for a second administration. If the applicant fails to show for a scheduled examination, a fee of $60.00 will be required before he/she may sit for the rescheduled examination. If the applicant fails the second administration, he/she must file a new application with a new fee of $78.00, and proof of further education/training to be tested a third time. The applicant may also take the examination two times on the second application but must adhere to the time frames and fees as stated above. If the applicant fails to honor any application within two (2) years of submitting, a new application with appropriate fees must be filed.**

Note: Please be aware that AMT's certification application forms are amended from time to time with changes impacting those eligibility requirements set forth in the application. Therefore, if you are submitting an application form that was printed several months or years ago, it may not disclose current criteria and conditions added subsequent to the printing of that form. All applicants are held to compliance with current eligibility requirements (including payment of current fee amounts) that are in place at the time of submission of their application, notwithstanding differences from the older, printed application being submitted. All current AMT certification applications are available for viewing and printing at AMT's website, www.amt1.com.

☐ Visa ☒ MasterCard ☐ Discover Card Credit card number: [redacted] Expiration: [redacted]

Name on Card: Janelle L. Gedmin Signature: Janelle Gedmin

If you are paying by check or money order, make payable to:

AMERICAN MEDICAL TECHNOLOGISTS

10700 West Higgins Road • Rosemont, Illinois 60018 • Phone (847) 823-5169 • Website www.amt1.com

By sending your completed, signed check to AMT, you authorize AMT to use the account information from your check to make a one-time electronic fund transfer

Patient History

Patient History: JANELLE GEDMIN (1045432) [redacted]

Balance	Date	Description	Code/Type	Units	Fee	Charges/Total
$0.00	08/28/2008	Visit				$80.00
	08/28/2008	Procedure [redacted]	99214	1	$80.00	$80.00
	08/28/2008	Diagnosis [redacted]	616.10			
	08/28/2008	Diagnosis [redacted]	789.00			
	08/28/2008	Payment - Patient	Copay Patient		$80.00	
$0.00	10/02/2008	Visit				$806.00
	10/02/2008	Procedure [redacted]	76830	1	$403.00	$403.00
	10/02/2008	Procedure [redacted]	76856	1	$403.00	$403.00
	10/02/2008	Diagnosis [redacted]	625.9			
	11/25/2008	Adjustment - Insurance	SIPA Adjustment		$485.00	
	11/25/2008	Payment - Insurance	SIPA Payment		$321.00	
	11/25/2008	Transfer - Insurance			($806.00)	
$0.00	12/30/2008	Visit				$98.00
	12/30/2008	Procedure [redacted]	88142	1	$0.00	$0.00
	12/30/2008	Procedure [redacted]	99213	1	$98.00	$98.00
	12/30/2008	Diagnosis [redacted]	616.10			
	12/30/2008	Diagnosis [redacted]	V25.01			
	12/30/2008	Diagnosis [redacted]	V72.31			
	12/30/2008	Adjustment - Insurance	Adjustment		$30.09	
	12/30/2008	Payment - Patient	Copay Patient		$15.00	
	02/22/2009	Adjustment - Insurance	SIPA Adjustment		($12.68)	
	02/22/2009	Payment - Insurance	SIPA Payment		$65.59	
	02/22/2009	Transfer - Insurance			$0.00	
$0.00	01/26/2009	Visit				$98.00
	01/26/2009	Procedure [redacted]	88142	1	$0.00	$0.00
	01/26/2009	Procedure [redacted]	99213	1	$98.00	$98.00
	01/26/2009	Diagnosis [redacted]	788.41			
	01/26/2009	Diagnosis [redacted]	795.08			
	01/26/2009	Adjustment - Insurance	Adjustment		$30.09	

Ex I

02/28/2009	Payment - Patient	Payment Patient	$15.00
03/10/2009	Payment - Insurance	Insurance Payment	$0.00
03/10/2009	Transfer - Insurance		$52.91
04/13/2009	Payment - Patient	Payment Patient	$52.91

BRIAN BOUTON, OD
1051 ESSINGTON RD., STE 200
JOLIET IL 60435

Telephone 815-729-3777

> Eye Dr.

Date Printed 09/29/09
Time Printed 05:58 PM

Fee Types: K I

Bill to A10053936

For Patient

JANELLE L GEDMIN
7618 W ST FRANCIS

FRANKFORT IL 60423

Date of Service	Product/ Service	Description	Qty	Insurance Amount	Patient Amount
		***** BILL # 478566 BILL DATE 05/24/08			
05/24/08	VISIONONLY	VISION PLAN USED	1		70.00
		DIAGNOSIS=367.1 [redacted]			
05/24/08		Payment--Thank you. Credit Card [redacted]			-5.00
06/28/08		Payment--VSP BENEFITS		-63.00	
06/28/08		Adjustment INSURANCE WRITE OFF		-2.00	
		BILL BALANCE TOTAL			

Outstanding Charges $ .00 <30 $ .00 >30 $ .00 >60 $ .00 >90 $ .00 >120

Total Due Now From Patient $ .00

Total Payment $ 68.00

Total Current Account Balance $ .00

Attended by
BRIAN BOUTON, OD

Fed ID # [redacted]

BC/BS #

State License #

WE ARE PLEASED TO ACCEPT DISCOVER/MC/VISA

ACCT #_____EXP_____PIN#____

AMOUNT:_____SIGNATURE_____

BRIAN BOUTON, OD
1051 ESSINGTON RD., STE 200

JOLIET IL 60435

Telephone 815-729-3777

Date Printed 09/29/09
Time Printed 06:00 PM

Fee Types: D

Bill to A10053936

JANELLE L GEDMIN
7618 W ST FRANCIS

FRANKFORT IL 60423

For Patient A10053719

DYLAN J DORCIC
7618 W ST FRANCIS RD

FRANKFORT IL 60423

Date of Service	Product/ Service	Description	Qty	Insurance Amount	Patient Amount
		***** BILL # 425856 BILL DATE 02/13/07			
02/13/07	92014	[redacted]	1		160.00
	DIAGNOSIS=368.00	[redacted]			
		Sent to IPA ILLINOIS DEPT PUBLIC AID			
		Filed with insurance on 02/14/07			
03/29/07		Payment--ILLINOIS DEPT PUBLIC		-44.45	
03/29/07		Adjustment INSURANCE WRITE OFF		-115.55	
		BILL BALANCE TOTAL			
		***** BILL # 425857 BILL DATE 02/13/07			
02/13/07	92310	[redacted]	1		55.00
02/13/07		Payment--Thank you. Credit Card[redacted]			-55.00
		BILL BALANCE TOTAL			
		***** BILL # 432582 BILL DATE 04/16/07			
04/16/07	CLFU	[redacted]	1		
04/16/07	V2520		2		130.00
04/16/07		Payment--Thank you. Electronic [redacted]			-130.00
		BILL BALANCE TOTAL			
		***** BILL # 454013 BILL DATE 10/18/07			
10/18/07	GLASSES	[redacted]	1		135.00
10/20/07		Payment--Thank you. Credit Card[redacted]			-135.00
		BILL BALANCE TOTAL			
		***** BILL # 476560 BILL DATE 05/06/08			
05/06/08	92012	[redacted]	1		100.00
	DIAGNOSIS=373.00	[redacted]			
		Sent to IPA ILLINOIS DEPT PUBLIC AID			
		Filed with insurance on 05/12/08			
05/06/08		Payment--Thank you. Credit Card[redacted]			-100.00
05/08/08		Adjustment OV TO IPA			100.00
06/16/08		Payment--ILLINOIS DEPT PUBLIC		-23.30	
06/16/08		Adjustment INSURANCE WRITE OFF		-76.70	
		BILL BALANCE TOTAL			
		***** BILL # 476561 BILL DATE 05/06/08			
05/06/08	92310	[redacted]	1		55.00

Date of Service	Product/ Service	Description	Qty	Insurance Amount	Patient Amount
DIAGNOSIS=367.0		[redacted]			
05/06/08		Payment--Thank you. Credit Card[redacted]			-55.00
05/08/08		[redacted]			55.00
05/29/08		Payment--Thank you. Check # [redacted]			-50.00
05/29/08		[redacted]			-5.00
05/06/08	[redacted]	[redacted]	1		70.00
DIAGNOSIS=367.0		[redacted]			
05/06/08		Payment--Thank you. Credit Card[redacted]			-42.00
05/08/08		[redacted]			32.00
05/29/08		Payment--Thank you. Check # [redacted]			-37.00
05/29/08		[redacted]			-23.00
05/06/08	[redacted]	[redacted]	1		363.00
DIAGNOSIS=367.0		[redacted]			
05/06/08		[redacted]			-34.30
05/06/08		Payment--Thank you. Credit Card[redacted]			-274.40
05/06/08		Payment--Thank you. Credit Card[redacted]			-34.30
05/08/08		Adjustment CRED APPLED TO CC			34.30
05/08/08		Adjustment APPLIED CREDIT BACK TO CC			32.90
05/08/08		Adjustment EYEMED DISC			-87.20
		BILL BALANCE TOTAL			
	***** BILL # 479228 BILL DATE 05/30/08				
05/30/08	[redacted]	[redacted]	1		
		BILL BALANCE TOTAL			
	***** BILL # 507813 BILL DATE 02/10/09				
02/10/09 92014		[redacted]	1		110.00
DIAGNOSIS=378.00		[redacted]			
		Sent to IPA ILLINOIS DEPT PUBLIC AID			
		Filed with insurance on 02/12/09			
03/11/09		Payment--ILLINOIS DEPT PUBLIC		-44.45	
03/11/09		Adjustment INSURANCE WRITE OFF		-65.55	
02/10/09 92015		[redacted]	1		42.00
DIAGNOSIS=367.0		[redacted]			
		Sent to IPA ILLINOIS DEPT PUBLIC AID			
		Filed with insurance on 02/12/09			
03/11/09		Payment--ILLINOIS DEPT PUBLIC		-18.45	
03/11/09		Adjustment INSURANCE WRITE OFF		-23.55	
		BILL BALANCE TOTAL			
	***** BILL # 518455 BILL DATE 05/12/09				
05/12/09	[redacted]	[redacted]	1		374.00
05/12/09		Adjustment DAVIS DISCOUNT			-116.10
05/12/09		Payment--Thank you. Credit Card[redacted]			-128.95
05/15/09		Adjustment TX CREDIT FRM B518457			-46.75
05/30/09		Payment--Thank you. Credit Card[redacted]			-82.20
		BILL BALANCE TOTAL			
	***** BILL # 518457 BILL DATE 05/12/09				
05/12/09 92310		[redacted]	1		55.00
05/12/09		Adjustment DAVIS DISCOUNT			-8.25
05/12/09		Payment--Thank you. Credit Card[redacted]			-46.75
05/15/09		Adjustment BILL DAVIS/TX TO 518457			46.75
05/15/09		Adjustment CX DISCOUNT/BILLING DAVIS			8.25

Date of Service	Product/ Service	Description	Qty	Insurance Amount	Patient Amount
06/15/09		Payment--Thank you. Check # [redacted]			-60.00
		BILL BALANCE TOTAL			-5.00
		***** BILL # 522626 BILL DATE 06/15/09			
05/12/09	VISIONONLY	VISION PLAN USED	1		70.00
		DIAGNOSIS=367.1 [redacted]			
06/15/09		Payment--Thank you. Check # [redacted]			-35.00
06/15/09		Adjustment DAVIS W/O			-35.00
		BILL BALANCE TOTAL			

Outstanding Charges $ .00 <30 $ .00 >30 Total Due Now =========
$ .00 >60 .00 >90 $ -5.00 >120 From Patient $ -5.00

=========
Total Payment $ 1396.25 Total Current Account Balance $ -5.00

Attended by
BRIAN BOUTON, OD
BRIAN BOUTON OD

Fed ID # [redacted] BC/BS # State License #

WE ARE PLEASED TO ACCEPT DISCOVER/MC/VISA

ACCT #_____EXP_____PIN#____

AMOUNT:_____SIGNATURE_____

BREMENTOWNE CHIROPRACTIC

15930 75TH COURT
TINLEY PARK, IL 60477
(708)532-2226

Page: 1

9/21/2009

Patient: Janelle L. Gedmin
7618 W. ST. FRANCIS RD.
FRANKFORT, IL 60423

Chart #: WOZNJA00
Case #: 116

Instructions:
Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
2/10/2006	INSURANCE WRITE-OFF	14						1	-5.79
2/9/2006	[redacted]	98941		722.52	724.2	739.3	728.85	1	40.00
2/21/2006	INSURANCE WRITE-OFF	14						1	-10.88
2/23/2006	INSURANCE WRITE-OFF	14						1	-42.10
2/23/2006	INSURANCE WRITE-OFF	14						1	-31.22
2/23/2006	INSURANCE WRITE-OFF	14						1	-20.34
2/23/2006	INSURANCE WRITE-OFF	14						1	-31.22
5/18/2006	CHECK PAYMENT	3						1	-50.00
6/21/2006	CHECK PAYMENT	3						1	-20.00
6/21/2006	CHECK PAYMENT	3						1	-30.00
7/19/2006	[redacted]	98941		722.52	724.2	739.3	728.85	1	40.00
7/19/2006	CHECK PAYMENT	3						1	-40.00
7/28/2006	CHECK PAYMENT	3						1	-35.00
8/28/2006	CHECK PAYMENT	3						1	-35.00
8/28/2006	CHECK PAYMENT	3						1	-5.00
9/29/2006	CHECK PAYMENT	3						1	-65.00
9/29/2006	CHECK PAYMENT	3						1	-70.00
9/29/2006	CHECK PAYMENT	3						1	-35.00
9/29/2006	CHECK PAYMENT	3						1	-34.21
9/29/2006	CHECK PAYMENT	3						1	-14.60
10/13/2006	CHECK PAYMENT	3						1	-40.00
10/13/2006	CHECK PAYMENT	3						1	-20.40
10/27/2007	[redacted]	98941		722.52	724.2	739.3	728.85	1	40.00
10/27/2007	CHECK PAYMENT	3						1	-40.00
9/4/2009	[redacted]	98940		722.52	724.2	739.3	728.85	1	40.00
9/4/2009	CHECK PAYMENT	3						1	-40.00
9/10/2009	[redacted]	98940		722.52	724.2	739.3	728.85	1	40.00

Provider Information

Provider Name: JASON A. KAAPKE D.C.
License: [redacted]
Commercial PIN:
SSN or EIN: [redacted]

Total Charges:	$ 200.00
Total Payments:	-$ 574.21
Total Adjustments:	-$ 141.55
Total Due This Visit:	**-$ 515.76**
Total Account Balance:	$ 0.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: _____ Date: _____

BREMENTOWNE CHIROPRACTIC

15930 75TH COURT
TINLEY PARK, IL 60477
(708)532-2226

9/21/2009

Patient: Janelle L. Gedmin
7618 W. ST. FRANCIS RD.
FRANKFORT, IL 60423

Chart #: WOZNJA00
Case #: 116

Instructions:
Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
9/10/2009	CHECK PAYMENT	3						1	-40.00
9/21/2009	[redacted]	98940		722.52	724.2	739.3	728.85	1	40.00
9/21/2009	CHECK PAYMENT	3						1	-40.00

Provider Information

Provider Name: JASON A. KAAPKE D.C.
License: 038009995
Commercial PIN:
SSN or EIN: [redacted]

Total Charges:	$ 40.00
Total Payments:	-$ 80.00
Total Adjustments:	$ 0.00
Total Due This Visit:	**-$ 40.00**
Total Account Balance:	$ 0.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: _____ Date: _____

ORLAND PRIMARY CARE SPECIALIST
16660 S. 107TH AVE
ORLAND PARK IL 60467
708/403-8500

P A T I E N T L E D G E R

DATE: 09/29/2009

ACCT / PTYPE: O63179 / VERIFY

PATIENT NAME: GEDMIN, JANELLE

GUARANTOR INFO:
JANELLE GEDMIN
7618 W ST FRANCIS RD
FRANKFORT, IL, 60423
815/469-0293

BALANCE NOW DUE $ .00

SVC DATE	SERVICE PERFORMED	CHARGE	INS PD	ADJUST	PAT PD	ON ACCT	BALANCE	DT PT RESP
10/06/08	GUARANTOR ON-ACCT	.00		.00		.00		
10/06/08	[redacted]	123.00	.00	108.00	15.00	.00	.00	
11/08/08	GUARANTOR ON-ACCT	.00		.00		.00		
11/08/08	[redacted]	71.00	.00	71.00	.00	.00	.00	
11/08/08	[redacted]	100.00	.00	85.00	15.00	.00	.00	
11/10/08	GUARANTOR ON-ACCT	.00		.00		.00		
11/10/08	[redacted]	100.00	.00	85.00	15.00	.00	.00	
12/20/08	[redacted]	.00		.00		.00		
12/20/08	[redacted]	100.00	.00	85.00	15.00	.00	.00	

TOTAL CHARGES.....$ 494.00
INSURANCE PAYMENTS.....$ .00
ADJUSTMENTS.....$ 434.00
PATIENT PAYMENTS (APPLIED).....$ 60.00
ON ACCT PAYMENTS (UNAPPLIED)...$ .00
ACCOUNT BALANCE.....$ .00
TOTAL PENDING INSURANCE.....$ .00
PATIENT BALANCE NOW DUE.....$ .00

Last Paid	Current	PAST DUE AMOUNTS 30 Days	60 Days	90 Days	120+ Days
12/20/08	.00	.00	.00	.00	.00

Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463

Hospital Billing Statement

00466

JANELLE L GEDMIN
7618 W SAINT FRANCIS RD
FRANKFORT, IL 60423-6931

Account Summary

Statement Date	11/27/08
Patient Name	JANELLE L GEDMIN
Account Number	H115421539
Service Date(s)	11/21/08
Total Charges	$2,166.40
Total Payments/Adj.	$0.00
Amount Pending Insurance	$2,166.40
Amount You Now Owe	$0.00

Insurance Information

Please confirm information is correct.

PRIMARY: HMO ILLINOIS
Policy # XOH836174016

SECONDARY: No secondary insurance on file. Please contact us if you have secondary insurance.

www.paloscommunityhospital.org

Important Message

Thank you for selecting Palos Community Hospital for your Healthcare needs. This is a summary of your charges for the date of service, 11/21/08. We have billed your insurance carrier. If there are any additional changes, please contact our Customer Service department at (708) 827-2200.

For Your Information

Itemized bills are available upon request, please call (866) 395-4723.

Please be aware that this statement reflects hospital charges only. You may receive separate bills from other providers and/or physicians. For your convenience, we have included the most frequently called numbers below:

Palos Anesthesia Associates	(847) 227-5150
Associated Cardiovascular Physicians	(630) 522-1100
Suburban Cardiology	(630) 325-9010
Palos Emergency Medical Services	(708) 430-8282
Palos Pathology Associates, Ltd.	(630) 874-2735
Southwest Rehabilitation	(773) 767-4600
Radiology & Nuclear Consultants, Ltd.	(708) 448-6300
Environmental & Respiratory (Dependable Business)	(708) 460-4499

Need Help?

If you are uninsured and live within this community, we may be able to assist you in obtaining financial assistance benefits through federal, state and our hospital program. Please contact the Business Office at (708) 827-2200 or (866) 395-4723 for more information.

If you would like to speak to a Customer Service representative or make payment over the phone, please call the Business Office at (708) 827-2200 or (866) 395-4723. Business hours are Monday through Friday, 8:00 A.M. until 4:30 P.M.

Need to send a fax?
The Business Office fax number is (708) 827-2261.

Please see back for detail...

PALOS PATHOLOGY ASSOCIATES, LTD
520 E 22nd ST
LOMBARD, IL 60148

FORWARDING SERVICE REQUESTED

STATEMENT DATE	AMOUNT DUE
01/11/2009	$12.00

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

PATIENT ACCOUNT NO. 141-1-0000875508

To pay online, go to www.patientonlinesystem.com

ADDRESSEE

JANELLE L. GEDMIN
7618 W SAINT FRANCIS RD
FRANKFORT, IL 60423-6931

MAKE CHECKS PAYABLE & REMIT TO:

PALOS PATHOLOGY ASSOCIATES, LTD
520 E 22nd ST
LOMBARD, IL 60148

DETACH HERE AND RETURN TOP PORTION WITH PAYMENT

Date of Service	Pos	Description	Qty	Code	Mod	Diag	Charge	Ins Payment	Pat Paymt	Adj	* Msg Code	Balance
12/17/2008	23	[redacted]	1	81025	26	054.2	7.00				001,	7.00
12/17/2008	23	[redacted]	1	81002	26	054.2	5.00				001,	5.00

Payments made within 7 days of the date below may not appear on this statement.

Date	Patient Name	Account Number	Tax ID Number	TOTAL DUE
01/11/2009	JANELLE L.GEDMIN	141-1-0000875508	[redacted]	$12.00

Place of Service	MAKE CHECK PAYABLE TO:
PALOS COMMUNITY HOSPITAL	PALOS PATHOLOGY ASSOCIATES, LTD

We have filed a claim to the address below. If any of this information is not correct, please notify us immediately.

0733
HMO ILLINOIS
BLUE SHIELD PROVIDER
PO BOX 805107

CHICAGO, IL 60680-4112

IMPORTANT MESSAGE(S) REGARDING YOUR ACCOUNT

001 SEND COPY OF INSURANCE ID CARD

WE FILED A CLAIM WITH YOUR INSURANCE COMPANY. PLEASE ALLOW 4-6 WEEKS FOR PROCESSING THIS CLAIM. IF AN INSURANCE PAYMENT IS ITEMIZED ON THIS STATEMENT, PLEASE REMIT THE BALANCE DUE. THANK YOU.

SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

FOR BILLING QUESTIONS CALL (630)874-2735

15530 01/01 R360-063 FORM -M-

TO MANAGE YOUR ACCOUNT ONLINE GO TO

M

PALOS COMMUNITY HOSPITAL
12251 S. 80TH AVENUE PALOS HEIGHTS, ILLINOIS 60463

02/10/09

Janelle L Gedmin
7618 W Saint Francis Rd

Frankfort, IL 60423-6931

Pd $100.00*
2-25-09
VH 43360

RE: JANELLE L GEDMIN
ACCT NO: H115522674
DATE OF SERVICE: 12/17/08
AMOUNT DUE: $100.00

Dear Janelle L Gedmin:

In reviewing your account we find your balance remains unpaid. Perhaps you have misplaced our previous statement. Your payment IN FULL is required unless other payment arrangements are made. Please remit balance in full, UPON RECEIPT OF THIS LETTER.

We can accept your payment by telephone for Visa, Mastercard, Discover, American Express, your Check-By-Phone or we can assist you in setting up a payment plan. You may also be eligible for financial assistance. You can contact us at (708)827-2200 or (866)395-4723 Monday through Friday from 8:30am to 4:00pm to provide the information we need.

Sincerely,

Patient Financial Services

Silver Cross Hospital
1200 Maple Road
Joliet IL 60432

Silver Cross Hospital
www.silvercross.org

JANELLE L GEDMIN
7618 W SAINT FRANCIS RD
FRANKFORT IL 60423-6931

Account Summary

Patient Name: JANELLE L GEDMIN
Patient Acc. #: F026139030
Admission Date: 7/16/09
Billing Date: 8/21/09
Total Due: $17.00

Insurance Information

Primary Ins: MEDICAID-ILLINOIS
Primary Policy #: 198694226

Account Activity

Description of Charge	Total Charge
[redacted]	$73.85
	$720.05
	$205.35
	$776.80
	$2,731.40
	$50.00
[redacted]T MEDICAID-IL CONTR	$340.40
PAYMENT MEDICAID-ILLINOIS; 20092160302	$-4,593.85
CHARGES TO DATE:	$-287.00
RECEIPTS TO DATE:	$4,897.85
ADJUSTMENTS TO DATE:	$287.00
ESTIMATED INSURANCE DUE:	$4,593.85
	$0.00

Questions

For a copy of your Itemized Bill or assistance in paying your bill, please call Customer Service.

If you feel you may qualify for the State Uninsured Patient Discount Act, please call Customer Service.

Silver Cross Hospital
1200 Maple Road
Joliet, IL 60432
Customer Service Hours: 8:00 a.m.- 4:15 p.m.
Customer Service #: (815) 740-7087

WE HAVE RECEIVED PAYMENT FROM YOUR INSURANCE COMPANY. IF ANOTHER INSURANCE WAS PROVIDED, WE WILL BILL. OTHERWISE THIS BALANCE IS YOUR RESPONSIBILITY. WE DO ACCEPT VISA, MASTERCARD, AND DISCOVER. THANK YOU. (815) 740-7087

Pd
8/28/09
✓ #
4370

HEDGES CLINIC
222 COLORADO AVENUE

FRANKFORT, IL 60423
815 469 2123

[CQFMAIN] Inquiry
Date 09/19/2009
Time 12:33p
User tempk
Page 1

Patient #: 119180
Bill To #: 119180
DOB: 04/07/1976
Age: 33 Sex: F
SSN: 000-00-0000
H/Ph #: 815-469-0293
W/Ph #: 000-0000

Patient Name: JANELLE GEDMIN
Resp Party: JANELLE GEDMIN
Dr #: 30 OREST HORODYSKY
RDr #:
Patient Type: 9 HFS/IDPA
Bill Cycle: 4 S - Z
Credit Status: 0
Date Registered: 05/18/2007

Patient E-mail:
Responsible Party E-mail:

Balances

0 - 30:	.00
31 - 60:	2.00
61 - 90:	4.00
91 - 120:	.00
121 - 150:	.00
151+ :	6.00-
Total Balance:	.00
- Pending:	.00
= Patient Balance:	.00
Budget Due:	.00
Non-budget Due:	.00
Total Due:	.00
Budget Balance:	.00
Budget Payment:	.00

Responsible Party Address:
7618 W ST FRANCIS RD

FRANKFORT, IL 60423

Patient Address:
7618 W ST FRANCIS RD

FRANKFORT, IL 60423

Last Transactions:

Charge:	07/28/2009	80.00
Personal:	02/12/2008	2.00
Insurance:	08/29/2009	356.72

Location: 1 HEDGES CLINIC
Diagnosis: 789.00 [redacted]
Billing History: 00/00/0000 00/00/0000
00/00/0000 00/00/0000

Current Coverages

Cov#	Insurance Company	Insurance Plan	Subscriber
1	2 HEALTHCARE AND		JANELLE GEDMIN
	Subscriber ID: 198694226		
	Patient ID:		

****
Debit mode details
****

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
06/27/2007	7152U	201/	30 O HORODYSKY	1 HEDGES CL	69.00	69.00

Cov#	Claim#	Ins Co# Name	Filed	Refiled	BA	PB	Status
1	71521	2 HEALTHCARE AND FAMIL	06/28/2007		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
06/26/2007-06/26/2007	99213	[redacted]		461.0	YYY	1.00	69.00	69.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
06/27/2007	5194U		1000001 CASH	2.00	2.00
08/09/2007	21355U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	26.35	26.35-
08/09/2007	21356U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	40.65	40.65-

	Paid	Write-off				
Primary:	26.35	40.65	Personal Paid:	2.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	26.35	40.65				

Patient#/Name: 119180 JANELLE GEDMIN

HEDGES CLINIC
222 COLORADO AVENUE

FRANKFORT, IL 60423
815 469 2123

[CQFMAIN] Inquiry
Date 09/19/2009
Time 12:33p
User tempk
Page 2

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
01/25/2008	42638U	204/	190 J LIMON	1 HEDGES CL	125.00	125.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	426381	2	HEALTHCARE AND FAMIL	01/29/2008		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
01/24/2008-01/24/2008	99214	[redacted]		V25.01	YYY	1.00	125.00	125.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
02/18/2008	102659U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	42.50	42.50-
02/18/2008	102660U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	82.50	82.50-

	Paid	Write-off				
Primary:	42.50	82.50	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	42.50	82.50				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
02/05/2008	45528U	254/danba	190 J LIMON	1 HEDGES CL	84.00	84.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	455281	2	HEALTHCARE AND FAMIL	02/15/2008		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
02/04/2008-02/04/2008	99213	[redacted]		623.5	YYY	1.00	69.00	69.00
02/04/2008-02/04/2008	87210	[redacted]		112.1	YYY	1.00	15.00	15.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
02/05/2008	97120U		1000001 CASH	2.00	2.00-
03/14/2008	116568U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	31.05	31.05-
03/14/2008	116569U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	52.95	52.95-

	Paid	Write-off				
Primary:	31.05	52.95	Personal Paid:	2.00	Total Balance:	2.00-
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	2.00-
Ins Total:	31.05	52.95				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
02/06/2008	46126U	203/	30 O HORODYSKY	1 HEDGES CL	215.50	215.50

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	461261	2	HEALTHCARE AND FAMIL	02/15/2008		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
02/05/2008-02/05/2008	99214	[redacted]		490	YYY	1.00	100.00	100.00
02/05/2008-02/05/2008	93000	[redacted]		490	YYY	1.00	50.00	50.00
02/05/2008-02/05/2008	85025	[redacted]		490	YYY	1.00	23.00	23.00
02/05/2008-02/05/2008	71020	[redacted]	27	490	YYY	1.00	42.50	42.50

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
02/06/2008	97540U		1000001 CASH	2.00	2.00-
03/14/2008	116529U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	81.05	81.05-
03/14/2008	116530U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	134.45	134.45-

	Paid	Write-off				
Primary:	81.05	134.45	Personal Paid:	2.00	Total Balance:	2.00-
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	2.00-
Ins Total:	81.05	134.45				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
02/12/2008	47069U	215/	30 O HORODYSKY	1 HEDGES CL	.00	.00

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
02/12/2008-02/12/2008		VOID			NNN	1.00	.00	.00

	Paid	Write-off				
Primary:	.00	.00	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	.00	.00				

HEDGES CLINIC
222 COLORADO AVENUE

FRANKFORT, IL 60423
815 469 2123

[CQFMAIN] Inquiry
Date 09/19/2009
Time 12:33p
User tempk
Page 3

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
02/12/2008	47129U	205/	30 O HORODYSKY	1 HEDGES CL	155.00	155.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	471291	2	HEALTHCARE AND FAMIL	02/19/2008		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
02/11/2008-02/11/2008	99213	[redacted]		490	YYY	1.00	69.00	69.00
02/11/2008-02/11/2008	85025	[redacted]		490	YYY	1.00	23.00	23.00
02/11/2008-02/11/2008	87804	[redacted]		490	YYY	1.00	30.00	30.00
02/11/2008-02/11/2008	81000	[redacted]		490	YYY	1.00	15.00	15.00
02/11/2008-02/11/2008	84703	[redacted]		490	YYY	1.00	18.00	18.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
02/12/2008	99747U		1000001 CASH	2.00	2.00-
03/14/2008	116533U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	62.70	62.70-
03/14/2008	116534U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	92.30	92.30-

	Paid	Write-off				
Primary:	62.70	92.30	Personal Paid:	2.00	Total Balance:	2.00-
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	2.00-
Ins Total:	62.70	92.30				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
06/27/2009	131619U	254/danba	30 O HORODYSKY	1 HEDGES CL	80.00	80.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	1316191	2	HEALTHCARE AND FAMIL	07/01/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
06/26/2009-06/26/2009	99213	[redacted]		461.0	YYY	1.00	80.00	80.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
07/25/2009	375936U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	44.56	44.56-
07/25/2009	375937U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	33.44	33.44-
07/25/2009	375938U	1	9000101 Co-ins 2.00	.00	.00

	Paid	Write-off				
Primary:	44.56	33.44	Personal Paid:	.00	Total Balance:	2.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	2.00
Ins Total:	44.56	33.44				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
07/07/2009	131837U	266/danba	30 O HORODYSKY	1 HEDGES CL	.00	.00

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
07/06/2009-07/06/2009		VOID			NNN	1.00	.00	.00

	Paid	Write-off				
Primary:	.00	.00	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	.00	.00				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
07/08/2009	133176U	156/wienl	30 O HORODYSKY	1 HEDGES CL	138.00	138.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	1331761	2	HEALTHCARE AND FAMIL	07/10/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
07/07/2009-07/07/2009	99214	[redacted]		789.00	YYY	1.00	115.00	115.00
07/07/2009-07/07/2009	85025	[redacted]		789.00	YYY	1.00	23.00	23.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
08/01/2009	379690U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	76.71	76.71-
08/01/2009	379691U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	59.29	59.29-
08/01/2009	379692U	1	9000101 Co-ins 2.00	.00	.00

	Paid	Write-off

HEDGES CLINIC
222 COLORADO AVENUE

FRANKFORT, IL 60423
815 469 2123

[CQFMAIN] Inquiry
Date 09/19/2009
Time 12:33p
User tempk
Page 4

Primary:	76.71	59.29	Personal Paid:	.00	Total Balance:	2.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	2.00
Ins Total:	76.71	59.29				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
07/18/2009	135348U	625/	30 O HORODYSKY	11 SILVER CR	1,750.00	1,750.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	1353481	2	HEALTHCARE AND FAMIL	07/21/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
07/16/2009-07/16/2009	45331	[redacted]		789.00	YYY	1.00	1,000.00	1,000.00
07/16/2009-07/16/2009	43239	[redacted]		789.00	YYY	1.00	750.00	750.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
08/29/2009	393087U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	356.72	356.72-
08/29/2009	393088U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	1,393.28	1,393.28-

	Paid	Write-off				
Primary:	356.72	1,393.28	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	356.72	1,393.28				

Patient#/Name: 119180 JANELLE GEDMIN

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
07/28/2009	135168U	156/wienl	30 O HORODYSKY	1 HEDGES CL	78.00	80.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	1351681	2	HEALTHCARE AND FAMIL	07/31/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
07/27/2009-07/27/2009	99213	[redacted]		789.00	YYY	1.00	80.00	80.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
08/14/2009	385635U	1	2000002 PMT HEALTHCARE AND FAMILY SRVS	44.56	44.56-
08/14/2009	385636U	1	4000002 W/O HEALTHCARE AND FAMILY SRVS	33.44	33.44-
08/14/2009	385637U	1	9000101 Co-ins 2.00	.00	.00

	Paid	Write-off				
Primary:	44.56	33.44	Personal Paid:	.00	Total Balance:	2.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	2.00
Ins Total:	44.56	33.44				

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9/28/09 - Pd $2.00*