

COLLECTION BUREAU
 MEDICAL ACCOUNTS ADMINISTRATION
 PO BOX 4127
 FT WALTON BEACH, FL 32549
 1-800-666-9567 (VOICE)
 850-864-1780 (FAX)
 www.reduceAR.com

Client Name _____

Address _____

Signed _____ Date _____

We are submitting the accounts and claims listed below to you for collection, subject to your established rates and conditions, whether the payment is made to you or to us. We will promptly report all payments received by us. Please act as our agent in clearing drafts and checks for collection. We understand that if because of an error, it becomes necessary to cancel any account, we will notify you immediately. However, any account that you have received promise of payment will not be cancelled without your full commission.

Last Name	First Name	Patient	Social Security#	Date of Birth	Home Ph #	Cell #
Street Address		City	State, Zip	Employer		Phone
Your Invoice#	Balance Owing	Date Last Charge	Additional Information			

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