



Patient Name

Account #

Statement Date

Sophia Jongsma

01034421

12/25/2025

AMOUNT
DUE

\$287.51

We have billed your insurance and the remaining balance is your responsibility. One or more of your charges are in **FINAL NOTICE**. Please see next step below.

**Make
Payment in
Full****To Make a Payment**

Pay your bill online at baycare.org/pay-my-bill or call us at (800) 940-5151 (Available 24/7)

**PAYMENT
PLANS**

If you are unable to pay your amount due in full and would like to establish a monthly payment plan, please contact us at (855) 533-5200 or log onto www.MedMaxFinance.com.

**FINANCIAL
ASSISTANCE**

If you are unable to pay, you may be eligible for financial assistance. Please call 727-394-6401.

**PAY
ONLINE
AT**personapay.com/bchc

Detach and return with your payment. Please make checks payable to BayCare HomeCare. Any changes to Address and/or Insurance should be noted on the back of the coupon.



BAYCARE HOMECARE
PO BOX 741704
ATLANTA GA 30374-1704

Pay online at <http://www.personapay.com/bchc>

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARD NUMBER		EXP. DATE	MUST INCLUDE SECURITY CODE FROM CREDIT CARD (CVV)
PRINT NAME			
SIGNATURE		AMOUNT	

STATEMENT DATE	AMOUNT DUE	PAYMENT DUE DATE
12/25/2025	\$287.51	Upon Receipt



SOPHIA JONGSMA
851 BRIGHTWATERS BLVD NE
ST PETERSBURG FL 33704-3719

BAYCARE HOMECARE
PO BOX 741704
ATLANTA GA 30374-1704



0000000010344210000287515

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:		Date of Injury
<input type="checkbox"/> AUTO ACCIDENT		
<input type="checkbox"/> WORKER'S COMPENSATION		

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	



Patient Name	Account #	Statement Date
Sophia Jongsma	01034421	12/25/2025

AMOUNT
DUE

\$287.51

STATEMENT OF SERVICES
(AS OF December 25, 2025)

Any Balance with FINAL NOTICE not paid in 30 days may be forwarded to a collection agency


DATE	HCPC CODE	QTY	DESCRIPTION	STATUS	BALANCE
9/10/2025	E0465	1	VENTILATOR	Final Notice	\$287.51

PAY ONLINE!  <http://www.personapay.com/bchc>

BALANCE DUE
UPON RECEIPT

\$287.51

CONTACT US FOR QUESTIONS ABOUT YOUR BILL

 **Call 727-394-6401.**

Monday thru Friday 8:00 am to 4:00pm