Stoughton Hospital
Trusted Care...Close to Home

Statement Date:

Patient Financial Services
Office Hours
Monday 7 a.m. – 6 p.m.
Tuesday – Friday 7 a.m. – 5 p.m.

Office Phone Number:
(608) 873-2257

Test Account
123 Test Street
Stoughton, WI 53589

Account Number

Account Number	1234567
Patient	Testp P Zzstotest
Total Charges	$$.$$
Balance Due	$$.$$
Payment Due Date	Date

Dear Testp,

Thank you for choosing Stoughton Hospital for your medical needs. Our mission is to provide all of our patients with safe, quality health care in a personalized manner.

Your insurance company has now paid its portion of your Stoughton Hospital visit dated (Date) This statement reflects hospital and urgent care/emergency room physician charges only. Radiologists and other providers will bill separately for their services.

You are expected to remit the balance due in full within 14 days of the statement date or make payment arrangements. We offer payment arrangements of varying lengths based on your needs.

If you have any questions or concerns, please contact us at (608) 873-2257.
Thank you for your prompt attention to this matter!

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT.

Make checks payable to: Stoughton Hospital, P.O. Box 78216, Milwaukee, WI 53278-0216.

For your convenience, we accept MasterCard, VISA or Discover. If paying by MasterCard, VISA or Discover, please fill out below.

Card Number:_____ Card Type:_____

Name on Card:_____ Signature:_____

Expiration Date:_____ Amount Paid:_____

Account Number	1234567 ← Account Number
Patient	Testp P Zzstotest
Balance Due – Pay This Amount	$$.$$