Person Treated (Name of Spouse or Dependent Child): _____

Date of Treatment	Payable to (Name of Healthcare Provider)	Total Bill	Amount Paid by Insurance	Balance not Paid by Insurance	Amount Paid by Petitioner	Amount due from Defendant	Date Defendant Notified
Ex:2/15/17	Dr. Jones	$500.00	$300.00	$200.00	$200.00	$0.00	2/15/17
Ex:3/15/17	Dr. Jones	$100.00	$50.00	$50.00	$50.00	$0.00	3/15/17
Ex;4/15/17	Dr. Jones	$200.00	$0.00	$200.00	$100.00	$100.00	4/15/17