JACKSON PURCHASE MED CTR
PO BOX 290429
NASHVILLE TN 372290429
http://WWW.JACKSONPURCHASE.COM
8552978330

Receipt Number	: 263915528	Transaction Type	: Payment
Customer	: MROCZKOWSK,MONIKA	Status	: Approved
Email	:	Original Tx No	:
Transaction Date(Central time)	: 07/24/2025 04:08 PM	Source	: HPS
Payment Made By Name	: MROCZKOWSK,MONIKA	Payment Mode	: Manual
Payment Reference	:		

Description	Patient	Responsible Party	Account #	Service Location ID	Reference ID	Transaction Amount
JACKSON PURCHASE MEDICAL CENTER	MROCZKOWSK,MONIKA	MROCZKOWSK,MONIKA	909267898	5387	263915528	$213.67
	Date of Service :	*Item Description : Payment*				*Remaining Balance: NA*

Payment Received	Transaction Amount
Credit Card : Visa ending 8090 Authorization : #098145 Processor Type : FD	$213.67

Thank you for your payment. Unless otherwise specified, partial payments made towards an existing balance are not accepted as payment in full.

I agree to pay the above amount according to the card issuer agreement.

Authorized Signature: _____

JACKSON PURCHASE MED CTR
PO BOX 290429
NASHVILLE TN 372290429
http://WWW.JACKSONPURCHASE.COM
8552978330

Receipt Number	: 263915288	Transaction Type	: Payment
Customer	: MROCZKOWSK,MONIKA	Status	: Approved
Email	:	Original Tx No	:
Transaction Date(Central time)	: 07/24/2025 04:06 PM	Source	: HPS
Payment Made By Name	: MROCZKOWSK,MONIKA	Payment Mode	: Cash
Payment Reference	:		

Description	Patient	Responsible Party	Account #	Service Location ID	Reference ID	Transaction Amount
JACKSON PURCHASE MEDICAL CENTER	MROCZKOWSK,MONIKA	MROCZKOWSK,MONIKA	909267898	5387	263915288	$500.00
	Date of Service :	*Item Description : Payment*				*Remaining Balance: NA*

Payment Received	Transaction Amount
	$500.00

Thank you for your payment. Unless otherwise specified, partial payments made towards an existing balance are not accepted as payment in full.

I agree to pay the above amount according to the card issuer agreement.

Authorized Signature: _____

Jackson Purchase Medical Center

Jackson Purchase Med Center
1099 Medical Cnt Circle
Mayfield, KY 42066
270-251-4100

ESTIMATED PATIENT FINANCIAL OBLIGATION SUMMARY

ROUTINE VENIPUNCTURE - 36415

Patient Name: MONIKA MROCZKOWSK	**Date of Birth:** 01/18/1993	**Service Date:** 07/24/2025
Physician:	**Account Number:** 909267898	**Visit ID:** 6984844
Primary Insurance: SELF PAY	**Policy Number:** 91791820	**Group Number:** 76570070

Patient/Guarantor Signature_____

Estimated Charges	Facility
Charges	$3,568.33
Self Pay Allowable	$1,427.33
Patient Est. Amount	**$1,427.33**
Additional Prompt Pay Discount	$285.47
Total Due Today	**$1,141.86**

30% 428.20

50% 713.67

Notes -

For additional questions regarding this estimate please contact 270-251-4100.

Visit ID: 6984844 Prepared By: nps.bab2 on 7/24/2025 5:00 PM

Jackson Purchase Med Center
1099 Medical Cnt Circle
Mayfield, KY 42066
270-251-4100

Good Faith Estimate – Estimate Details

Patient Name: MONIKA MROCZKOWSK
Date of Birth: 01/18/1993
Service Date: 07/24/2025
Patient Address: 200 WEST FARTHING ST MAYFIELD KY - 42066
Phone Number: (270) 705-8558
Email Address:
Visit ID: 6984844

The following is a detailed list of expected charges for ROUTINE VENIPUNCTURE - 36415, scheduled for 7/24/2025.

Separate good faith estimates will be issued to an uninsured individual upon scheduling or upon request of the listed items or services and that for items or services included in this list.

Facility

Jackson Purchase Med Center **NPI: 1891892741** **TIN: 621757927**

Code	Description	Units	Expected Charges	Expected Self Pay Charges
36415	ROUTINE VENIPUNCTURE (1 1 Each units)	1	$95.25	$38.10
85025	COMPLETE CBC W/AUTO DIFF WBC (1 1 Each units)	1	$304.88	$121.95
80053	COMPREHEN METABOLIC PANEL (1 1 Each units)	1	$599.68	$239.87
83735	ASSAY OF MAGNESIUM (1 1 Each units)	1	$154.33	$61.73
84443	ASSAY THYROID STIM HORMONE (1 1 Each units)	1	$242.64	$97.06
84436	ASSAY OF TOTAL THYROXINE (1 1 each units)	1	$154.33	$61.73
84480	ASSAY TRIIODOTHYRONINE (T3) (1 1 each units)	1	$271.37	$108.55
86376	MICROSOMAL ANTIBODY EACH (1 1 Each units)	1	$138.33	$55.33
86039	ANTINUCLEAR ANTIBODIES (ANA) (1 1 each units)	1	$561.37	$224.55
82728	ASSAY OF FERRITIN (1 1 each units)	1	$382.06	$152.82
83540	ASSAY OF IRON (1 1 Each units)	1	$202.22	$80.89
86431	RHEUMATOID FACTOR QUANT (1 1 each units)	1	$330.97	$132.39
86235	NUCLEAR ANTIGEN ANTIBODY (1 1 Each units)	1	$130.90	$52.36
		Subtotal	$3,568.33	$1,427.33

For additional questions regarding this estimate please contact 270-251-4100.