

Wellness Partners Mental Health Billing

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PATIENT STATEMENTS

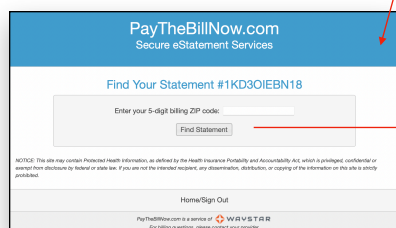
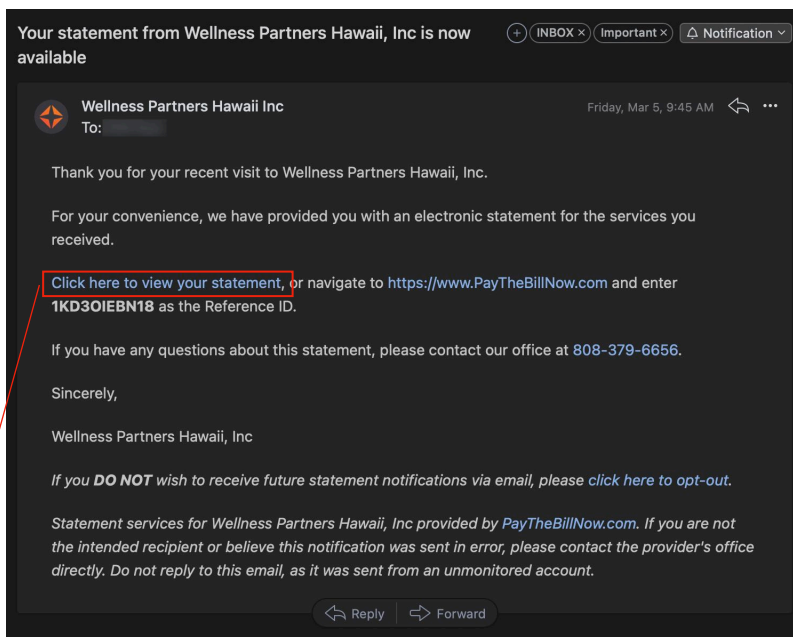
Email

Official patient statement notifications will be emailed on the **1st** of each month to the email address on file. **Originating email will be coming from no-reply@paythebillnow.com.** Please double check your spam/junk folder.

Click on the link saying **"Click here to view your statement"**, enter your **zip code**, and click **Find Statement**.

Online

Your patient statement will always be available to view, download and print online via your patient portal: <http://wphintouch.insynchcs.com/> under Billing. The online patient statement will display all itemized charges, past, present and outstanding.



AUTOMATIC PAYMENTS

If you have a saved payment method on file with our office, it will be automatically charged **21 days** after your electronic billing statement is transmitted.

When multiple cards are saved for a patient, the software will first try to make the payment from the recently used card. If there is no payment history, then it will pick the 1st card on top, if the payment fails, it will pick 2nd, and so forth.

Wellness Partners Hawaii, Inc.
Secure eStatement Services on PayTheBillNow.com

Statement #1KD3OIEBN18

Wellness Partners Hawaii, Inc
850 West Hind Drive Suite 210
Honolulu, HI 96821

For Billing Questions Please Call:
808-379-6656

ADDRESSSEE: [Redacted]

MAKE CHECKS PAYABLE/REMIT TO:
Wellness Partners Hawaii, Inc
850 West Hind Drive Suite 210
Honolulu, HI 96821

DATE	PROVIDER	PATIENT	DESCRIPTION	FEE	BALANCE
01/26/2021	Bradley Kuo	[Redacted]	PSYCHIATRIC DIAGNOSTIC EVALUATION	200.00	200.00
01/26/2021	Bradley Kuo	[Redacted]	tax*	10.00	10.00

Statement Date	Account #	Current	30 Days	60 Days	90 Days	Billing Questions
03/05/2021	0000000174	10.00	200.00	0.00	0.00	808-379-6656

Total Balance	210.00
*Insurance Pending	
AMOUNT NOW DUE	210.00

If you DO NOT wish to receive future statement notifications via email, please [click here to opt-out](#).

ONLINE BILL PAY THROUGH THE PATIENT PORTAL

Recommended browser, Google Chrome.

Please enable cookies in your browser security settings in order for online bill pay to work properly.

Please log into your patient portal <http://wphintouch.insynchcs.com/> . **Click/tap on Billing**. You will be able to see your statement and itemized amounts, past and present.

On the right top corner, **click/tap ePayNow**. A ePayment window will appear. Leave the Card# drop down menu at Select and **click/tap Pay**. You will be directed to a second ePayment screen to enter your credit card information. **Fill out** the required **information**: Card Number (Account number) , Exp. Date, CCV and Email. **Click/tap Submit**. You will receive a receipt in your email inbox.

If you wish to make a payment over the phone, or have any billing related inquiries, please contact 808.379.6656.

Wellness Partners Mental Health reserves the right to use your credit card on file, consented by you in the signed Treatment and Communication Consent Agreement, for any fees and balances over 31 days old associated with the care provided by your provider.

My Bills

My Statement | Ledger | Online Payment Log | Payment Receipt

210.00 | ePayNow

Wellness Partners Hawaii, Inc.
850 West Hind Drive Suite 210
Honolulu, HI 96821
Phone: 808-379-6656 Fax: 808-379-3750

Card Number: Exp Date: Amount:
Signature: 3 or 4 digit security code:
Record # (MRN) Statement Date Amount Due (\$)
000000174 03/05/2021 210.00

Patient Name: [REDACTED]

Wellness Partners Hawaii, Inc.
PO Box 26062
Honolulu, HI 96825

For all billing questions, call 808-379-6656

Date	Provider	Service Code	Description	Charge (\$)	Payment (\$)	Balance (\$)			
07/11/2019									
07/16/2019						0.00			
07/23/2019						0.00			
10/08/2019						0.00			
07/23/2019						0.00			
10/08/2019						0.00			
01/26/2021						200.00			
01/26/2021						10.00			
Current (\$)				31 to 60 Days (\$)	61 to 90 Days (\$)	91 to 120 Days (\$)	121+ Days (\$)	Unapplied Credit (\$)	Total (\$)
0.00				210.00	0.00	0.00	0.00	0.00	210.00
								Amount Due (\$)	210.00

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ePayment

Patient: [REDACTED]

Payment Amount (\$): 210.00

Card # (ConsentId): [Select]

Pay

ePayment

Payment Information

Patient MRN #: 000000174

Patient FirstName: [REDACTED]

Patient LastName: [REDACTED]

Address 1: [REDACTED]

Address 2: [REDACTED]

City: [REDACTED]

State: [REDACTED]

CardHolder FirstName: [REDACTED]

CardHolder LastName: [REDACTED]

Billing Zip: [REDACTED]

Card Number: [REDACTED]

Exp Date: [REDACTED] (MM/YY) CVV/CVD: [REDACTED]

Amount: \$210.00

Email: [REDACTED]

Submit

Cancel