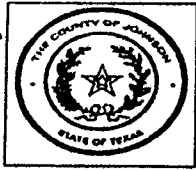


Approved by CC:



PURCHASE ORDER
JOHNSON COUNTY, TEXAS

NOV 18 2013

PURCHASE ORDER	
No.	JVP111201
Refer to this number on all invoices and communications	

Vendor: Heart of Texas General Surgery
125 South Park Dr., Ste E
Brownwood, TX 76801

Date	11/12/2013
Dept. Code	590
Dept. Name	Juvenile Probation
Contract Awarded Date	
Contract and Bond Approved Date	
Requisition Number	

Deliver To: Juvenile Probation
ATTN: Lisa Tomlinson
1102 E. Kilpatrick, Ste C
Cleburne, Tx 76033

Quantity	Description	Distribution	Unit Price	Total
1	Surgeon's Cost, DHarris		\$1,885.00	\$1,885.00
			TOTAL:	\$1,885.00

Approved by CC:

NOV 18 2013

\$1055.60

Budget provisions have been made and funds are available or will be available to meet this obligation when due, provided there is proper and legal performance.

Approved By: Kelli Davis, (PC)
Purchasing Agent

Date: 11-12-2013

Mail Invoices To: Purchasing Department
1102 E. Kilpatrick, Ste B
Cleburne, TX 76031

Handwritten initials

10-08-13;01:51PM;

Oct 8 2013 01:51pm

P001

:3256410418
Dr. Ullrich

1 / 1



Heart of Texas GENERAL SURGERY

125 South Park Dr, Suite B - Brownwood, Texas 76801 - P: (325)641-2384 - F: (325)641-0418

Date: October 8, 2013 Time: 1:31pm AM/PM

Patient Name: Damen Harris DOB: 9/22/2013

PLAN: G45 The Oaks PLAN PHONE #: (817) 646-5383

PLAN ID: _____ GR #: _____

ELIGIBILITY DATE: _____ PLAN TYPE: _____

TYPE OF CONTACT: _____ (WEB SITE, AUTOMATED, OR REPRESENTATIVE. PLEASE NOTE FIRST NAME AND FIRST INITIAL OF LAST NAME OF REPRESENTATIVE AND. REF # IF AVAILABLE)

Procedure Date: _____

REFERRAL: YES NO

REFERRAL#: _____

PREAUTHORIZATION: YES NO
(PRECERT OR NOTIFICATION)

AUTH #: _____

COPAY(S): _____

COINSURANCE: _____

DEDUCTIBLE: _____

MET _____ REMAINING _____

OUT OF POCKET: _____

MET _____ REMAINING _____

Doc decided 10/8/2013 1:30pm

PROC Lap Cholecystectomy \$ 1865.00 CPT 47563 DX Biliary Dysk ICD 575.8

PROC Intraoperative \$ 20.00 CPT 76000, 26 DX _____ ICD _____

PROC Cholangiogram \$ _____ CPT _____ DX _____ ICD _____

Total \$ 1885

DEDUCTIBLE: (-) \$ _____
If the patients' remaining deductible is more than the amount due the, patient will owe the entire allowable amount due.

SUBTOTAL: \$ 1885

COPAY/OFFICE VISIT: \$ _____

CO-INSURANCE: \$ _____ (%)

PATIENT PORTION: \$ _____ (%)

DEDUCTIBLE: (+) \$ _____

Estimated Portion Due: \$ 1885

This is only an ESTIMATE of charges. If there is an outstanding balance after services are completed, a statement of charges will be sent to you and/or your insurance when applicable.