

# PCSO COLLECTION ACCOUNTS LISTING SHEET

The following accounts are submitted to Professional Collection Services of Ohio (PCSO) for collection at the usual collection rate. I understand that collection fees shall be based upon all payments received after listing whether paid directly to my practice/business or to PCSO. Please submit this form to: PCSO, Inc., PO Box 353, Sandusky, OH 44871-0353 or Fax to 419-627-0486.

Request PCSO Representative to call.

## Please Provide A Copy Of Each Debtor's Last Statement.

Client Information							
Practice/Business Name:							
Address:				City:		State:	Zip:
Phone:		Date:		PCSO Client #:			
Practice/Business Authorized Signature:				Title:		Date:	
Client Account Information							
Account Or Debtor #:			Mail Return? <input type="checkbox"/> Yes <input type="checkbox"/> No		Debt Disputed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Individual(s) Who Received Services or Product: (Additional Information On Reverse Side <input type="checkbox"/> Yes <input type="checkbox"/> No)					Date of Last Payment?		
1. _____	Date of Debt: _____		Charge	\$ _____	<b>Total Charges</b>		\$ _____
2. _____	Date of Debt: _____		Charge	\$ _____	<b>Interest</b>		\$ _____
3. _____	Date of Debt: _____		Charge	\$ _____			_____
4. _____	Date of Debt: _____		Charge	\$ _____	<b>Total Due</b>		\$ _____
Debtor Information				Debtor's Spouse or Other Liable Individual			
Name:				Name:			
Address:				Address:			
City:	State:	Zip:	Phone:	Home Phone:			
SSN:		Date of Birth:		SSN:		Date of Birth:	
Employer Name:			Phone:	Employer Name			Phone:
Relationship To The Individual(s) Who Received Services or Product:				Relationship To The Patient:			
<input type="checkbox"/> Self <input type="checkbox"/> Parent or Legal Guardian <input type="checkbox"/> Other _____				<input type="checkbox"/> Spouse <input type="checkbox"/> Other Liable Individual _____			