2002 UNIFORM BUSINESS REPORT (UBR)

FILED
May 28, 2002 8:00 am
Secretary of State
05-28-2002 90712 049 ***150.00

DOCUMENT # G33225

1. Entity Name
PORTER GRIFFIN ENTERPRISES, INC.

Principal Place of Business	Mailing Address
335 PREVATT RD DOTHAN AL 36301	P.O. BOX 1792 DOTHAN AL 36302

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 59-2294937 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
HARRIS, ERIC D 912 MAPLE AVENUE PANAMA CITY FL 32401	Name Street Address (P.O. Box Number is Not Acceptable) City **FL** Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.

SIGNATURE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) ☒

FILE NOW!!! FEE IS $150.00
After May 1, 2002 Fee will be $550.00
Make Check Payable to Department of State

10. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

11. OFFICERS AND DIRECTORS			12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P GRIFFIN, PORTER G. 335 PREVATT RD DOTHAN AL 36301	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V HARRIS, ERIC 2412 ARKANAS ST. LYNN HAVEN FL 32444	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ST GRIFFIN, LINDA H 335 PREVATT ROAD DOTHAN AL 36301	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition

CR2E034 (9/01)

13. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: Porter G. Griffin ENDRED 08- May-02
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Attachment

866652 / #G33225

PORTER GRIFFIN ENTERPRISES, INC.
P. O. BOX 1792
DOTHAN, AL 36302-1792
(334) 671-7632

MAY 8, 2002

FLORIDA DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
P. O. BOX 6327
TALLAHASSEE, FL 32314

DEAR SIRS:

ENCLOSED PLEASE FIND COPIES WHERE I WAS HOSPITALIZED IN JANUARY, FEBRUARY AND APRIL 2002. DUE TO MY ILLNESS AND HOSPITALIZATIONS, I MISPLACED THE 2002 UNIFORM BUSINESS REPORT PACKET. IT WAS NOT UNTIL RECENTLY THAT I WAS ABLE TO LOCATE THE PACKET.

I AM REQUESTING THAT THE LATE FEES BE ABATED BECAUSE OF THE REASONS ABOVE.

THANKING YOU IN ADVANCE.

Porter Griffin

PORTER GRIFFIN

ENCLOSURES

PS I would like to fill out application for automated bank draft for 2003.

SOUTHEAST ALABAMA MED CTR
ATTN:
US HWY 84 E POB 6987
DOTHAN AL 36302

ADDRESS SERVICE REQUESTED

017534L

Attachment 866652 / # G133225

CREDIT CARD PAYMENT INFORMATION	
CARD TYPE	EXP. DATE
ACCOUNT NUMBER	
CARD HOLDER SIGNATURE	

PLEASE PAY THIS AMOUNT

PATIENT NAME	
GRIFFIN, PORTER GRADY	
PATIENT NUMBER: 001 6092222	DISCHARGE / SERVICE DATE: 01/10/02
CURRENT BALANCE: 100.00	BILLING DATE: 01/25/02
AGREEMENT AMOUNT: .00	PAYMENT DUE DATE: 04/18/02
100.00	ENTER AMOUNT PAID HERE ►

SOUTHEAST ALABAMA MED CTR
ATTN:
US HWY 84 E POB 6987
DOTHAN, AL 36302

526

PORTER GRADY GRIFFIN
335 PREVATT RD
DOTHAN AL 36301

2040694

☐ PLEASE CHECK HERE AND SHOW NAME/ADDRESS CORRECTION ON REVERSE SIDE

DETACH HERE TO ASSURE PROPER CREDIT PLEASE WRITE YOUR PATIENT NUMBER ON YOUR CHECK AND RETURN UPPER PORTION WITH REMITTANCE

DATES MAY REFLECT POSTING DATE OR SERVICE DATE

DATE	DESCRIPTION	QUANTITY	AMOUNT
	PREVIOUS BALANCE		100.00

IMPORTANT MESSAGE

THANK YOU FOR CHOOSING SAMC. FOR QUESTIONS REGARDING YOUR BILL, PLEASE CONTACT THE PATIENT ACCOUNTS DEPARTMENT AT (334) 793-8711.

PATIENT NUMBER 001 2040694

FOR INQUIRIES CALL (334) 793-8111

FOR YOUR CONVENIENCE, A DROP BOX IS LOCATED OUTSIDE OF PATIENT ACCOUNTS.

DISCHARGE/ SERVICE DATE	01/10/02
AGREEMENT AMOUNT	.00

PATIENT NAME: GRIFFIN, PORTER GRADY
PATIENT NUMBER: 001 6092222

ACCOUNT SUMMARY

PREVIOUS BALANCE	100.00
NEW CHARGES	.00
PAYMENTS/ OTHER ADJUSTMENTS	.00
CURRENT ACCOUNT BALANCE	100.00
PAYMENT DUE DATE	04/18/02
PAY THIS AMOUNT	100.00

RETAIN THIS PORTION

PAYMENTS RECEIVED AFTER BILLING DATE WILL APPEAR ON NEXT STATEMENT

MAKE CHECKS PAYABLE TO:
FIRST MED OF DOTHAN
1245 WESTGATE PARKWAY
DOTHAN AL 36303

Forwarding Service Requested

Attachment
866652
#G33225

STATEMENT

IF PAYING BY CREDIT CARD, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT ☐ VISA ☐ MasterCard		
CARD NUMBER		AMOUNT
SIGNATURE		EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT.#
18-APR-02	19.60	26509

Phone (334) 702-3548
Page 1 of 1

SHOW AMOUNT PAID HERE $

FIRST MED OF DOTHAN
1245 WESTGATE PKWY
DOTHAN AL 36303-2151

**********AUTO**5-DIGIT 36301
00002912 1 AV 0.255 01
MR. PORTER G GRIFFIN
335 PREVATT RD
DOTHAN AL 36301-4875

☐ Check box if your address is incorrect or if insurance information has changed.
Indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

Date	Description	Procedure	Qty	Diag	Phy	LO	PLS	Amount
	BALANCE FORWARD							203.10
03/11/02	CHEK PT: OVER COUNT.PYMT.				20			0.20-
03/11/02	CHEK PT: OVER COUNT.PYMT.				20			12.90-
03/11/02	CHEK PT: OVER COUNT.PYMT.				20			15.00-
03/11/02	OFFICE VIS.EST PT LEV 3	99213	1	530.11	20	FM	3	50.00
03/21/02	556 0725685				20			
03/21/02	CO-INS: 15.00				20			
03/21/02	PMD				20			
03/21/02	PMT: BLUE CROSS/SHIELD OF				20			29.00-
04/04/02	556 0725686				2H			
04/04/02	556 0725686				2H			
04/04/02	556 0725686				2H			
04/04/02	CO-INS: 3.90				2H			
04/04/02	CO-INS: 6.30				2H			
04/04/02	CO-INS: 9.40				2H			
04/04/02	PMD				2H			
04/04/02	PMD				2H			
04/04/02	PMD				2H			
04/04/02	PMT: BLUE CROSS/SHIELD OF				2H			35.10-
04/04/02	PMT: BLUE CROSS/SHIELD OF				2H			56.70-
04/04/02	PMT: BLUE CROSS/SHIELD OF				2H			84.60-

Abbreviations/Codes

Diagnosis: 530.11 - REFLUX ESOPHAGITIS
Location: FM - FIRST MED OF DOTHAN
Physician: 20 - PAULK MD, CHARLES TED
2H - PAULK M.D., C. TED

Provider Medicare #: 18990
18990

Notes:
We accept Visa, MasterCard and Discover. Call 702-3548 to pay by phone.

Current	31 - 60 Days	61 - 90 Days	Over 90 Days	- Ins. Pending	Amount Due
19.60					

MAKE CHECKS PAYABLE TO:

GASTROENTEROLOGY ASSOC., P.A.

4300 WEST MAIN ST. SUITE 102
DOTHAN AL 36305-1051
Forwarding Service Requested

Hadnot 866652

#G33225

STATEMENT

IF PAYING BY CREDIT CARD, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT ❑ VISA ❑ MasterCard		
CARD NUMBER		AMOUNT
SIGNATURE		EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT.#
24-APR-02	40.00	76547

Phone (334) 793-9564
Page 1 of 1

SHOW AMOUNT PAID HERE $

GASTROENTEROLOGY ASSOC. P.A.

4300 W MAIN ST STE 102
DOTHAN AL 36305-1051

**********AUTO**5-DIGIT 36301
00004057 1 AV 0.255 01
MR. PORTER GRADY GRIFFIN
335 PREVATT RD
DOTHAN AL 36301-4875

❑ Check box if your address is incorrect or insurance information has changed. Indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

Date	Pat	Procedure	Description	Qty	Diag	Phy	Loc	Insurance	Patient
02/13/02	01	99214	OV/OPS; EST; DETAILED	1	786.50	CR	03	90.00	
02/13/02			CASH PT: WINDOW PAYMENT			CR		15.00-	
02/28/02			WRT-OFF: PMD			CR		34.00-	
02/28/02			PMT: BLUE CROSS OF ALABAM			CR		41.00-	
02/13/02			FILED: $90 Y BLUE CROSS			CR			0.00
		**** Subtotal of Claim 00013:						0.00	0.00
03/18/02	01	99213	OV/OPS; EST; EXPANDED	1	536.8	TA	03	60.00	
03/26/02			COPAY			TA		15.00-	15.00
03/28/02			WRT-OFF: PMD			TA		16.00-	
03/28/02			PMT: BLUE CROSS OF ALABAM			TA		29.00-	
03/18/02	01	86318QW	ANTIBODY,SNG STEP;H-PYLOR	1	536.8	TA	03	25.00	
03/26/02			LAB NOT COVERED			TA		25.00-	25.00
03/28/02			No PMT: BLUE CROSS OF ALA			TA		0.00	
03/18/02			FILED: $85 Y BLUE CROSS			TA			0.00
		**** Subtotal of Claim 00014:						0.00	40.00

Abbreviations/Codes

Patient: 01 - GRIFFIN, PORTER GRADY
Location: 03 - GASTROENTEROLOGY ASSOCIATES (PLS: 3
Physician: CR - CRITTENDEN, M.D., JEFFREY J.
TA - TARWATER M.D., SAMUEL J.

Provider Medicare #: 81876
88663

Notes:
Please pay the amount due by the 10th of the month. Thank you.
Questions: Insurance Dept. 712-2990 Billing Dept. 712-2991

Current	31 - 60 Days	61 - 90 Days	Over 90 Days	Amount Due
40.00	0.00	0.00	0.00	40.00