Summary of Unpaid Medical Services

Patient Name: [Insert Patient Name]

Account Number: [Insert Account Number]

Total Balance Due: $[Insert Total Amount]

Date of Service	Description of Services	Amount Owed
[Insert Date]	[Insert Description]	$[0.00]
[Insert Date]	[Insert Description]	$[0.00]

Please note that the amounts listed above are currently past due. If you have recently made a payment or have insurance coverage pending for these dates, please contact our billing department immediately.

Payment Instructions:

[Insert Payment Methods/Portal Link]