[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: Notice of Financial Responsibility for Upcoming Procedure

Dear [Patient Name],

This letter is to provide you with information regarding your financial responsibility for your upcoming procedure, [Procedure Name], scheduled on [Date] at [Location].

Based on the information provided by your insurance carrier, [Insurance Company Name], the estimated costs are as follows:

- Total Estimated Facility/Provider Fee: $[Amount]
- Estimated Insurance Coverage: $[Amount]
- **Your Estimated Out-of-Pocket Responsibility: $[Amount]**

Please note that this is only an estimate. The final balance may vary based on actual services rendered, changes in insurance processing, or additional findings during the procedure. Your responsibility may include deductibles, co-payments, or co-insurance amounts as defined by your specific insurance plan.

Payment of your estimated portion is requested [at the time of check-in / by Date]. We accept the following payment methods: [List Payment Methods].

If you have questions regarding your coverage, we recommend contacting your insurance provider directly. For questions regarding our billing process or to discuss payment arrangements, please call our billing office at [Phone Number].

Sincerely,

[Sender Name/Department]
[Facility/Practice Name]
[Phone Number]