[Date]

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

Subject: Notification of Copayment and Deductible Responsibility

Dear [Patient Name],

Thank you for choosing [Practice/Facility Name] for your healthcare services. We are writing to provide information regarding your financial responsibility for your upcoming or recent visit on [Service Date].

Based on the insurance coverage information provided to us by [Insurance Company Name], your estimated out-of-pocket responsibility is as follows:

- **Copayment:** $[Amount]
- **Estimated Deductible Amount:** $[Amount]
- **Total Estimated Patient Responsibility:** $[Total Amount]

Please be advised that copayments are due at the time of service. Deductible amounts are determined by your insurance carrier's specific plan benefits. The amounts listed above are estimates; you will be billed for any remaining balance after your insurance provider processes the claim.

If you have questions regarding your specific coverage or how these amounts were calculated, please contact your insurance provider's member services department at the number listed on your insurance card.

For questions regarding payment options or to set up a payment plan, please contact our billing office at [Phone Number] or [Email Address].

Sincerely,

[Sender Name/Billing Department]
[Practice/Facility Name]