[Provider Name/Clinic Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]
[Tax ID Number]

[Date]

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

RE: Annual Summary of Medical Expenses for Tax Year [Year]

Dear [Patient Name],

This letter serves as an official summary of the out-of-pocket medical expenses paid by you to [Provider Name] for the calendar year [Year]. This document is provided for your records and may be used for tax deduction purposes.

Date of Service	Description of Service	Amount Paid
[MM/DD/YYYY]	[Service Type/Office Visit]	$[0.00]
[MM/DD/YYYY]	[Service Type/Procedure]	$[0.00]
Total Paid in [Year]:		**$[0.00]**

Please note that this summary only includes payments received between January 1, [Year] and December 31, [Year]. It does not include any amounts covered or paid by your insurance provider.

If you have any questions regarding this statement, please contact our billing office at [Phone Number].

Sincerely,

[Authorized Signature]
[Printed Name]
[Title/Office Manager]