[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[Date]

RE: Annual Medical Expense Summary - [Tax Year]

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient Account Number: [Account Number]

Dear [Patient Name],

As requested, please find a summary of your out-of-pocket medical expenses paid to [Practice Name] for the calendar year [Year]. This statement is provided for your personal records or tax purposes.

Date of Service	Description of Service	Patient Payment Amount	Payment Method
[Date]	[Office Visit/Co-pay/Procedure]	$[Amount]	[Credit/Cash/Check]
Total Paid in [Year]:		**$[Total Amount]**	

Please note: This summary only reflects payments made directly to this primary care office. It does not include payments made to pharmacies, laboratories, imaging centers, or specialists unless billed through our facility. Amounts covered or paid by your insurance provider are not included in the totals above.

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

Sincerely,

[Staff Name/Billing Manager]
[Practice Name]