[Provider or Clinic Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Annual Medical Expense Summary - Tax Year [Year]
Patient Account Number: [Account Number]

Dear [Patient Name],

This letter provides a summary of the medical expenses incurred at our facility for the calendar year [Year]. This statement is provided for your records and potential tax purposes.

Date of Service	Description of Service	Total Charges	Insurance Payments	Patient Payments
[Date]	[Service]	$[0.00]	$[0.00]	$[0.00]
Total Patient Responsibility Paid:				**$[Total Paid]**

Current Account Balance: $0.00

As of [Date], your account balance is zero. There are no outstanding payments due for the [Year] calendar year. We appreciate your prompt attention to your account throughout the year.

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

Sincerely,

[Signature]
[Name of Billing Manager/Office Manager]
[Provider or Clinic Name]