[Clinic Name]
[Clinic Address]
[Clinic Phone Number]
[Date]

[Patient Name]
[Patient Address]
[Patient ID/Account Number]

Annual Medical Expense Summary: [Year]

Dear [Patient Name],

As the calendar year concludes, we are providing this summary of your medical expenses and payments at [Clinic Name] for the period of January 1, [Year] through December 31, [Year]. This document may be useful for your personal records, insurance verification, or tax purposes.

Date of Service	Description of Service	Billed Amount	Insurance Paid	Patient Paid
[Date]	[Service/Procedure]	$[0.00]	$[0.00]	$[0.00]
			Total Patient Responsibility Paid:	**$[Total Amount]**

Please note that this summary only reflects payments posted to your account during this calendar year. Payments made to outside laboratories, imaging centers, or pharmacies are not included in this statement.

If you have any questions regarding this summary or your account balance, please contact our billing department at [Phone Number] or [Email Address].

Thank you for choosing [Clinic Name] for your specialized healthcare needs.

Sincerely,

[Billing Manager Name/Signature]
[Clinic Name] Billing Department