

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

**Subject: Letter of Financial Clearance / Statement of Zero Balance**

Dear [Patient Name],

This letter serves as official confirmation that the account for [Patient Name] (Account Number: [Account Number]) at [Medical Facility Name] has been paid in full.

As of [Date], our records show a zero (\$0.00) balance for all services rendered between [Start Date] and [End Date]. There are no outstanding invoices, co-payments, or fees remaining on this account.

Please retain this letter for your personal records or for submission to insurance providers or credit agencies if required.

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

Sincerely,

[Staff Name/Signature]

[Title/Department]

[Medical Facility Name]