[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Notice of Outstanding Balance
Patient ID: [ID Number]
Account Number: [Account Number]

Dear [Patient Name],

This is a routine notification regarding the balance on your account for medical services provided on [Date of Service].

Our records indicate that there is an outstanding balance of **$[Amount Due]**. This amount remains due after your insurance provider, [Insurance Company Name], processed the claim. A brief summary of the charges is provided below:

- Total Charges: $[Amount]
- Insurance Paid: $[Amount]
- Patient Responsibility: $[Amount]

Please remit payment at your earliest convenience. You may pay by mail using the enclosed envelope, by phone at [Phone Number], or via our online patient portal at [Website URL].

If you have already sent your payment or if you believe there is an error regarding this statement, please contact our billing department at [Phone Number] so we can update your records.

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

Sincerely,

[Billing Department Name]
[Clinic Name]