Date:

 Patient: Mrs.

 **TO Whom This May Concern**

This Letter should serve as a proof that the Patient Referenced above has paid in full (Zero Balance) the amount of **$2,000** as of July 15, 2018.

**This Payment includes the following services:**

|  |  |  |
| --- | --- | --- |
| Service Description | Dates | Remarks |
| Doctor fee for [Vagina/ C-Section] Delivery |  July 10, 2018 |  |
| Pre Natal Care (Office Visits) On: | June 15, 2018, June 22, 2018June 29, 2018, July 06, 2018 |  |
| Ultrasounds Done on: | June 15, 2018, July 06, 2018 |  |
| NST Done on: | June 15, 2018, July 06, 2018 |  |
| Post-Partum Care (Office Visit) on: | July 15, 2018 |  |

This Payment does NOT Include any hospital charges.

If you have any further questions or require any additional information,

Please contact our office at (973) 473-5053

Sincerely,

Administration