Date:

 Patient: Mrs. **FIRST NAME LAST NAME**

 **TO Whom This May Concern**

This Letter should serve as a proof that the Patient Referenced above has been seen at our Office by **Dr. Hesham El Mokadem** and paid in full the amount of **$2,100** for Services related to Prenatal, Delivery and Postnatal Care and her **balance is Zero.**

**This Payment includes the following services:**

|  |  |  |
| --- | --- | --- |
| Service Description | Date | $ Price |
| Doctor fee for [Vaginal/ C-Section] Delivery |  July 10, 2023 |  |
| Pre Natal Care (Office Visits) On: | June 15, 2023, June 22, 2023June 29, 2023, July 06, 2023 |
| Ultrasounds Done on: | June 15, 2023, July 06, 2023 |
| Post-Partum Care (Office Visit) on: | July 15, 2023 |
| TOTAL |  | **$2,100** |

This Payment does NOT Include any hospital charges.

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

Please contact our office at (951) 734-7200

Sincerely,

Administration