

HEALTHCARE SPENDING LOG

Period: _____

Patient Name: _____

DATE	PROVIDER / SERVICE	CATEGORY	INSURANCE PAID	TOTAL BILL	OUT OF POCKET
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DATE

PROVIDER / SERVICE

CATEGORY

**INSURANCE
PAID**

**TOTAL
BILL**

**OUT OF
POCKET**

Subtotal:

\$ _____

Tax Deductible:

\$ _____

GRAND TOTAL:

\$ _____