

Medical Industry Tax Preparation Expense Summary

Tax Year: _____

Client Information

Practice / Business Name (if applicable): _____

Provider Name: _____

Address: _____

Phone: _____ **Email:** _____

Business Structure:

- Sole Proprietor
- Partnership
- LLC
- S Corporation
- C Corporation

EIN (if applicable): _____

Medical Profession:

- Physician
 - Nurse Practitioner / PA
 - Registered Nurse
 - Dentist / Dental Hygienist
 - Chiropractor
 - Therapist / Counselor
 - Pharmacist
 - Medical Consultant
 - Other: _____
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Income

Patient / Client Service Income: \$ _____

Insurance Reimbursements: \$ _____

Hospital / Facility Pay: \$ _____

Telehealth Income: \$ _____

Consulting / Expert Witness Income: \$ _____

Other Medical Income: \$ _____

Please attach:

- 1099-NEC / 1099-MISC
- W-2s
- Insurance payment summaries
- EHR billing reports
- Practice management reports

Medical Supplies & Clinical Expenses

Medical Supplies: \$ _____

Disposable Supplies (gloves, masks, syringes, etc.): \$ _____

Prescription/Procedure Supplies: \$ _____

Sterilization Supplies: \$ _____

Lab Fees / Testing Costs: \$ _____

Vaccines / Pharmaceuticals (if applicable): \$ _____

Medical Equipment (small tools): \$ _____

Equipment & Technology

Medical Devices: \$ _____

Diagnostic Equipment: \$ _____

Computer Equipment: \$ _____

EHR / EMR Software: \$ _____

Practice Management Software: \$ _____

Billing Software: \$ _____

Telehealth Platforms: \$ _____

Office / Practice Expenses

Office Rent / Clinic Lease: \$ _____

Utilities: \$ _____

Office Supplies: \$ _____

Furniture & Fixtures: \$ _____

Cleaning Services: \$ _____

Security Systems: \$ _____

Repairs & Maintenance: \$ _____

Staff & Contract Labor

Medical Assistants: \$ _____

Nurses / Clinical Staff: \$ _____

Administrative Staff: \$ _____

Contract Physicians / Locums: \$ _____

Billing / Coding Services: \$ _____

Payroll Taxes: \$ _____

Professional Fees & Licensing

Medical License Fees: \$ _____

DEA Registration: \$ _____

Board Certifications: \$ _____

Hospital Privileges Fees: \$ _____

Malpractice Insurance: \$ _____

Professional Association Dues: \$ _____

Continuing Medical Education (CME): \$ _____

Medical Journals & Subscriptions: \$ _____

Insurance

Malpractice Insurance: \$ _____

Health Insurance (Self-Employed Portion): \$ _____

Disability Insurance: \$ _____

Business Liability Insurance: \$ _____

Travel & Education

CME Conferences: \$ _____

Hotel & Lodging: \$ _____

Airfare / Transportation: \$ _____

Meals While Traveling: \$ _____

Medical Conferences & Seminars: \$ _____

Mileage for Patient Visits: _____ Miles

Marketing & Professional Development

Website & Online Presence: \$ _____

Advertising (if allowed): \$ _____

Referral Network Costs: \$ _____

Professional Photography / Branding: \$ _____

Patient Education Materials: \$ _____

Communication Expenses

Cell Phone (Business Portion): \$ _____

Internet: \$ _____

Fax / Secure Communication Systems: \$ _____

Postage & Medical Records Requests: \$ _____

Banking & Administrative Expenses

Bank Fees: \$ _____

Credit Card Processing Fees: \$ _____

Accounting & Bookkeeping Fees: \$ _____

Tax Preparation Fees: \$ _____

Legal Fees: \$ _____

Facilities & Specialized Costs

Radiology Services (if outsourced): \$ _____

Lab Outsourcing: \$ _____

Medical Waste Disposal: \$ _____

HIPAA Compliance Systems: \$ _____

Licensing / Accreditation Fees: \$ _____

Assets Purchased During the Year

Please list major equipment or assets purchased:

Description Date Purchased Cost

Examples:

- Ultrasound machines
 - Dental chairs
 - Surgical equipment
 - Computers / servers
 - Office buildout improvements
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Home Office (If Applicable)

Used for administrative/telehealth purposes:

Yes No

Home Square Footage: _____

Office Square Footage: _____

Mortgage Interest or Rent: \$ _____

Utilities: \$ _____

Internet: \$ _____

Repairs (Entire Home): \$ _____

Repairs (Office Only): \$ _____

Retirement Contributions

SEP IRA: \$ _____

Solo 401(k): \$ _____

401(k) / 403(b): \$ _____

Traditional IRA: \$ _____

Roth IRA: \$ _____

Estimated Tax Payments

Federal Estimated Taxes: \$ _____

State Estimated Taxes: \$ _____

Dates Paid: _____

Other Expenses

Please list any additional medical business expenses:

Description	Amount
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	\$ _____
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	\$ _____
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	\$ _____
--	----------

	\$ _____
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Questions

Did you change practice locations this year?

Yes No

Did you add new providers or staff?

Yes No

Did you purchase or sell medical equipment?

Yes No

Did you receive any grants, incentives, or relief funds?

Yes No

Did you work under multiple facilities or contracts?

Yes No

Additional Notes

Client Certification

I certify that the information provided is complete and accurate to the best of my knowledge. I understand that supporting documentation may be required.

Client Signature: _____

Date: _____