

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

RE: FINAL NOTICE AND TERMINATION OF PROFESSIONAL RELATIONSHIP

Dear [Patient Name],

This letter serves as formal notification regarding the outstanding balance on your account in the amount of \$[Amount]. Despite our previous attempts to resolve this matter through multiple statements and phone calls, we have not received payment or a request to establish a payment plan.

Please be advised that your account is now seriously delinquent. If payment is not received in full by [Date], your account will be referred to an external collection agency, which may impact your credit rating.

Furthermore, due to the non-payment of your financial obligations, we regret to inform you that we are terminating the provider-patient relationship at [Practice Name], effective thirty (30) days from the date of this letter. This decision is final.

We will continue to provide you with emergency care and necessary prescriptions for the next 30 days, until [End Date], to allow you sufficient time to find a new healthcare provider. After this date, we will no longer provide any medical services to you.

To facilitate the transition of your care, we will provide a copy of your medical records to your new physician upon receipt of a signed authorization form. You may contact our office at [Phone Number] to request this form or to settle your balance immediately via credit card.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Provider Name or Practice Manager]

[Practice Name]