[Hospital or Clinic Name]
[Department Name - e.g., Radiology]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

[Date]

[Patient Full Name]
[Patient Address Line 1]
[City, State, Zip Code]

RE: FINAL WARNING - Missed Diagnostic Imaging Appointment

Dear [Patient Name],

Records indicate that you failed to attend your scheduled diagnostic imaging appointment for a [Type of Scan, e.g., MRI/CT/X-ray] on [Date of Appointment] at [Time]. This is the [Number] missed appointment for this procedure.

Diagnostic imaging is a critical part of your medical care. Failure to complete this scan prevents your physician from accurately diagnosing or monitoring your condition, which may lead to a delay in necessary treatment.

This is your final notice. If you do not contact our office to reschedule this appointment within [Number, e.g., 5] business days, your current referral for this imaging will be cancelled. To reschedule, please call our department at [Phone Number] during regular business hours.

Please be advised that future missed appointments or failures to provide at least 24-hour notice for cancellations may result in a "No-Show" fee or discharge from this specialty clinic.

We look forward to hearing from you promptly to ensure your health needs are met.

Sincerely,

[Staff Name/Department Manager]
[Department Name]
[Facility Name]

cc: [Referring Physician Name]