[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: SECOND NOTICE - Surgical Procedure No-Show and Fee Assessment

Dear [Patient Name],

This letter serves as a second formal notice regarding your missed surgical appointment scheduled for [Date of Surgery] at [Time] with [Doctor/Surgeon Name].

Our records indicate that you did not attend this scheduled procedure and failed to provide the required [Number of Hours/Days] notice for cancellation. As stated in our previous communication and our signed office policy, missed surgical appointments result in a non-refundable no-show fee.

Fee Assessment Details:

- Missed Procedure Date: [Date]
- No-Show Fee Amount: $[Amount]
- Payment Due Date: [Date]

The preparation for a surgical procedure involves significant coordination of medical staff, equipment, and facility resources. When an appointment is missed without notice, it prevents other patients from receiving necessary care.

Please contact our billing department at [Phone Number] to settle this balance. If you wish to reschedule your surgery, please note that the assessed fee must be paid in full, and a new surgical deposit may be required.

If you believe this notice has been sent in error, or if there were extreme extenuating circumstances, please contact our Office Manager immediately.

Sincerely,

[Sender Name/Practice Name]
[Phone Number]
[Email Address]