[Date]

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

**RE: FINAL WARNING - Missed Surgical Procedure and Fee Assessment**

Dear [Patient Name],

This letter serves as a formal final warning regarding your missed surgical appointment scheduled for [Date of Surgery] at [Time]. Our records indicate that you did not attend this procedure and failed to provide the required [Number] hours of advance notice for cancellation.

As stated in our signed financial policy, missed surgical appointments result in a significant loss of resources and prevent other patients from receiving necessary care. Consequently, a non-refundable "No-Show Fee" of $[Amount] has been assessed to your account.

Please be advised of the following:

- The balance of $[Amount] is due immediately.
- Future surgical procedures will not be rescheduled until this fee is paid in full.
- Repeated failure to adhere to our attendance policy may result in the formal termination of the physician-patient relationship.

If there were extreme extenuating circumstances regarding your absence, please contact our Billing Department at [Phone Number] within [Number] days to discuss your account.

We value your health and wish to continue providing your medical care, but we require strict adherence to our scheduling policies moving forward.

Sincerely,

[Authorized Signature]
[Name of Practice/Surgical Center]
[Contact Information]