[Your Name/Practice Name]
[Billing Department Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Notice of Missed Surgical Procedure Fee

Dear [Patient Name],

This letter is to inform you that our records indicate you missed your scheduled major surgical procedure on [Date of Surgery] at [Time] without providing the required [Number of Hours] hours of advance notice for cancellation.

As outlined in our signed patient financial policy, scheduled surgeries require significant coordination of medical staff, operating room availability, and specialized equipment. When a surgery is missed without prior notification, it prevents other patients from receiving necessary care.

Consequently, a missed surgery penalty fee of $[Amount] has been applied to your account. Please note that insurance providers do not cover fees for missed appointments; therefore, this balance is your personal responsibility.

Account Summary:

- Procedure Type: [Name of Procedure]
- Date of Missed Appointment: [Date]
- Penalty Fee Amount: $[Amount]
- Due Date: [Date]

Please remit payment at your earliest convenience. You may pay by mail, by phone, or through our online patient portal at [Website URL].

If you believe this fee has been charged in error, or if you faced an extreme medical emergency that prevented you from calling, please contact our billing office at [Phone Number] to discuss your account.

Sincerely,

[Signature]
[Printed Name/Title]
[Practice Name]