[Facility Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: INVOICE FOR SURGICAL NO-SHOW / LATE CANCELLATION

Dear [Patient Name],

This letter is to inform you that our records indicate you did not attend your scheduled surgical procedure on **[Date of Surgery]** at **[Time]**. Furthermore, we did not receive a cancellation notice within the required **[Number of Hours/Days]** timeframe as outlined in our signed financial policy.

Scheduling a surgery involves the coordination of a surgical suite, anesthesia providers, nursing staff, and specialized equipment. When a patient does not arrive, these resources remain idle, preventing other patients from receiving necessary care.

Assessment Details:

- **Scheduled Procedure:** [Procedure Name]
- **No-Show/Late Cancellation Fee:** $[Amount]

Please find the enclosed invoice for the amount listed above. Payment is due by **[Due Date]**. You may pay this balance via [Payment Method/Online Portal/Phone].

If you experienced an unavoidable medical emergency that prevented you from attending or calling, please contact our billing department at [Phone Number] to discuss a one-time waiver assessment.

If you wish to reschedule your surgery, please contact our surgical coordinator. Please note that a deposit may be required to secure a future surgical date.

Sincerely,

[Sender Name/Signature]
[Title]
[Facility Name]