[Date]

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

Re: Notice of Surgical No-Show / Late Cancellation Fee

Dear [Patient Name],

This letter is to inform you that we have recorded a missed appointment for your scheduled surgical procedure on [Date of Surgery] with [Physician Name].

Our records indicate that:

- You did not arrive for your scheduled surgery time.
- Your cancellation was received less than [Number of Hours/Days] prior to the procedure.

As outlined in our signed financial policy, surgical procedures require significant coordination of staff, equipment, and facility time. Because we were unable to fill this reserved time on short notice, a fee of $[Amount] has been assessed to your account.

Please note that insurance providers do not cover fees for missed appointments; therefore, this balance is your personal responsibility. You may remit payment by mail, online through our portal, or by calling our billing office at [Phone Number].

If you wish to reschedule your surgery, please contact our surgical coordinator at [Phone Number]. Please be advised that future surgical dates may require a pre-payment or deposit.

If you believe this fee has been charged in error, or if you experienced an unavoidable medical emergency, please contact us to discuss your situation.

Sincerely,

[Practice Name]
[Billing Department/Office Manager Name]
[Phone Number]