[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: NOTICE OF DISCHARGE FROM MEDICAL CARE

Dear [Patient Name],

This letter is to formally notify you that [Practice Name] is terminating the physician-patient relationship with you, effective 30 days from the date of this letter. This decision has been made due to your repeated failure to appear for scheduled surgical procedures on [Date 1], [Date 2], and [Date 3].

Consistent attendance is vital for the coordination of surgical teams and facility resources. Because these appointments were missed without prior notice, a "No-Show Fee" of $[Amount] has been assessed to your account for each occurrence. Your current outstanding balance is $[Total Balance]. Please remit payment by [Due Date].

We will continue to provide emergency medical care and necessary prescriptions for the next 30 days, ending on [Date]. This period allows you sufficient time to establish care with a new provider. After this date, we will no longer provide any medical services to you.

We recommend that you contact your insurance provider or local medical society to assist you in finding a new physician. Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider to ensure continuity of care.

Sincerely,

[Physician Name/Practice Manager]
[Practice Name]