[Date]

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

RE: TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

This letter serves as formal notice that [Practice Name] is terminating its professional relationship with you, effective 30 days from the date of this letter. This decision has been made due to your continued outstanding financial balance of $[Amount], despite our multiple attempts to reach a payment resolution.

Please be advised of the following regarding your transition of care:

- **Emergency Care:** For the next 30 days (until [Date]), our providers will be available to treat you for emergency medical situations only.
- **Medical Records:** We will provide a copy of your medical records to your new physician upon receipt of a signed authorization form. You may contact our office to obtain this form.
- **New Provider:** You will need to find a new healthcare provider immediately. We recommend contacting your insurance carrier or the local medical society for a list of available physicians in your area.
- **Prescriptions:** Any necessary prescription refills will be provided only during the 30-day notice period.

Your account remains past due. We urge you to remit the full balance of $[Amount] immediately to avoid further collection actions.

Sincerely,

[Doctor Name/Practice Administrator]
[Practice Name]
[Phone Number]