[Date]

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

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide medical care to you effective [Date - typically 30 days from letter date]. This decision has been made due to your accumulative financial obligations and a failure to reach a mutually agreed-upon payment plan regarding your outstanding balance.

Until the date mentioned above, we will remain available to provide emergency care and necessary prescriptions. This notice period is intended to give you sufficient time to establish a relationship with another healthcare provider.

We recommend that you contact your insurance provider or the local medical society to assist you in locating a new physician. Once you have selected a new provider, please sign the enclosed medical record release form and return it to our office. We will promptly forward a copy of your medical records to your new physician to ensure continuity of care.

Thank you for your immediate attention to this matter.

Sincerely,

[Physician Name/Practice Administrator]
[Practice Name]

Enclosure: Medical Record Release Form