[Date]

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

RE: NOTICE OF DISMISSAL FROM MEDICAL PRACTICE

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you effective [Date - typically 30 days from letter date]. This decision has been made due to the continued non-payment of your outstanding balance, which currently totals $[Amount].

Despite our previous attempts to resolve this matter through billing statements and phone calls, we have not received the necessary payment or an established payment plan.

For the next 30 days, until [Date], we will remain available to provide you with emergency medical care and necessary prescriptions only. This grace period is intended to give you sufficient time to locate a new healthcare provider. We recommend you contact your insurance carrier or local medical society to find a new physician.

Upon receiving a signed authorization form from you, we will transfer a copy of your medical records to your new provider to ensure continuity of care.

If you wish to settle your account immediately to prevent this dismissal, please contact our billing department at [Phone Number] no later than [Date].

Sincerely,

[Physician Name/Administrator Name]
[Practice Name]