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

[Date]

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

RE: Notice of Termination of Medical Services

Dear [Patient Name],

Please be advised that [Practice/Facility 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 default on your financial account. Despite previous notices sent to you on [Date of previous notice] and [Date of previous notice], your balance of $[Amount] remains unpaid.

Until [Date], we will be available to provide you with emergency medical care only. This notice period is intended to give you sufficient time to locate a new healthcare provider. We recommend contacting your insurance company or the local medical society for a list of available providers in your area.

Upon receiving a signed authorization form from you, we will transfer a copy of your medical records to your new physician. You may pick up an authorization form at our office or request one by mail.

If you wish to settle your outstanding balance immediately to discuss the possibility of reinstating your care, please contact our billing department at [Phone Number] no later than [Date].

Sincerely,

[Provider Signature]
[Printed Name and Title]