

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you effective [Date - 30 days from letter].

This decision has been made due to your continued refusal to adhere to the financial policies of this practice, specifically regarding [Reason, e.g., non-payment of balances/refusal to provide insurance information]. Despite our previous attempts to resolve this matter, the outstanding requirements remain unfulfilled.

We will continue to provide emergency medical care and necessary prescriptions for the next 30 days, until [Date]. This period is intended to allow you sufficient time to establish care with another healthcare provider.

We recommend that you contact your insurance carrier or the 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.

Thank you for your immediate attention to this matter.

Sincerely,

[Doctor Name/Practice Manager]

[Practice Name]