[Date]

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

Subject: Notice of Financial Responsibility

Dear [Patient Name],

Welcome to [Practice/Clinic Name]. We are committed to providing you with the best possible care. To ensure a clear understanding between our office and our patients, we are providing this notice regarding our financial policies.

Insurance Coverage: It is your responsibility to provide current and accurate insurance information. While we may assist in verifying your benefits, it is ultimately your responsibility to know what your insurance plan covers, including any requirements for referrals or prior authorizations.

Co-payments and Deductibles: All co-payments, co-insurance, and unmet deductibles are due at the time of service. We accept [List Payment Methods, e.g., Cash, Credit Card, Check].

Non-Covered Services: If your insurance company determines that a service is "not covered," or if you are uninsured, you will be personally responsible for the total balance of the bill.

Cancellations and No-Shows: We require [Number] hours' notice for cancellations. Failure to provide notice may result in a fee of $[Amount], which is not covered by insurance.

Agreement: By signing our new patient intake forms, you acknowledge that you have read and understand your financial obligations to [Practice/Clinic Name].

If you have any questions regarding these policies, please contact our billing department at [Phone Number] or [Email Address].

Sincerely,

[Provider/Manager Name]
[Practice/Clinic Name]