[Date]

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

Subject: Uninsured Patient Financial Responsibility Notice

Dear [Patient Name],

This letter is to inform you of your financial responsibilities regarding the medical services provided at [Facility/Clinic Name] on [Date of Service].

Our records indicate that you are currently seeking treatment as an uninsured patient. Please be advised of the following policies:

- **Payment Obligation:** You are personally responsible for the full payment of all professional services, procedures, and supplies provided to you.
- **Estimated Costs:** The estimated cost for today's visit is $[Amount]. Please note that this is only an estimate and final charges may vary based on the actual services rendered.
- **Payment Timeline:** Payment is expected [at the time of service / within X days of billing].
- **Self-Pay Discount:** We offer a [Percentage]% discount for patients paying in full at the time of service.

If you are unable to pay the full balance, we offer financial assistance programs and interest-free payment plans. To discuss these options or to apply for a sliding fee scale, please contact our Billing Department at [Phone Number] or visit [Website/Office Location].

By signing below, you acknowledge that you have read this notice and understand your financial obligation to [Facility/Clinic Name].

Sincerely,

[Authorized Signature]
[Printed Name and Title]
[Facility Name]

Patient Acknowledgement:

Signature: _____ Date: _____