

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: Notification of Expiring Payment Information

Dear [Patient Name],

This letter is to inform you that the payment method currently on file for your medical account is set to expire on **[Expiration Date]**.

To ensure there is no interruption in your billing cycle or scheduled payments, please update your account information by [Action Deadline Date].

You can update your information through one of the following methods:

- Online: [Link to Patient Portal]
- Phone: Call our billing department at [Phone Number]
- In-Person: Visit the front desk during your next appointment

If you have already updated your information, please disregard this notice.

Thank you for your prompt attention to this matter.

Sincerely,

[Billing Department Name]

[Medical Facility Name]

[Contact Phone Number]