

**DATE:** [Insert Date]

**TO:**

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

**FROM:**

[Clinic Name or Law Firm Name]  
[Address]  
[City, State, Zip Code]  
[Phone Number]

**RE: NOTICE OF INTENT TO FILE LAWSUIT / FORMAL DEMAND FOR PAYMENT**

**Account Number:** [Insert Account Number]

**Total Amount Due:** \$[Insert Amount]

Dear [Patient Name],

This letter serves as formal notice regarding your delinquent balance for medical services provided by [Clinic Name] on [Date of Service]. Despite previous requests for payment, your account remains unpaid.

Please be advised that we have authorized the commencement of legal action against you to recover the outstanding debt, plus applicable interest, court costs, and legal fees. A lawsuit may result in a court judgment allowing for the garnishment of wages or the attachment of personal property.

You can avoid this legal action by taking one of the following steps within [Number, e.g., 10] days of the date of this letter:

- Pay the full balance of \$[Insert Amount].
- Contact our office at [Phone Number] to establish a formal payment plan.

Remit payment to the following address:

[Insert Payment Address]  
[City, State, Zip Code]

If we do not receive payment or a response by [Insert Deadline Date], we will proceed with filing the summons and complaint in the appropriate court without further notice to you.

Sincerely,

[Your Name/Signature]

[Title]

[Clinic/Firm Name]

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This is an attempt to collect a debt. Any information obtained will be used for that purpose.