

[Your Name or Practice Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

Subject: Termination of Professional Relationship

Dear [Patient/Client Name],

Please be advised that [Practice Name] is terminating its professional relationship with you, effective [Date, typically 30 days from letter date]. This decision has been made due to your repeated missed appointments on [Date 1], [Date 2], and [Date 3].

Consistent attendance is necessary to provide you with effective care. Our records show that despite previous notifications regarding our attendance policy, these missed appointments have continued to occur.

Between now and [Termination Date], we will be available to provide [emergency care/limited services] only. This notice period is intended to give you sufficient time to locate a new provider.

We recommend that you contact your insurance provider or [Local Referral Resource] to assist you in finding a new professional. Upon your written authorization, we will transfer a copy of your records to your new provider.

Thank you for your cooperation in this matter.

Sincerely,

[Your Signature]
[Your Printed Name and Title]