[IMPORTANT: Send letter via Certified Mail]

[Insert your letterhead]

[Insert date]

[Insert patient name]
[Insert patient address]

Dear Mr./Mrs. Patient:

This letter is to notify you of our intent to dismiss you as a patient from our practice unless your outstanding balance is paid in full within 10 business days from the receipt of this letter. We have made numerous attempts to collect on your outstanding balance with our practice. To date our records indicate that there has been no payment activity on your account, which is 60 days past due in the amount of $[Insert dollar amount here].

We have requested payment through a series of statements that have been sent to you at the above address. Additionally, we provided you a copy of our financial policy, which you acknowledged with your signature, during your initial visit at our practice. **[Attach, if available a copy of the signed financial policy. Please note that all new patients should be presented with your financial policy at the initial registration outlining your expectations regarding payment and your dismissal policy.]**

At this time, you will need to contact our office at _____to pay the amount in full immediately or you will be formally dismissed from our practice as a patient. Unless your account is paid in full immediately, we regret that we may take the additional following actions:

- **Your account will be turned over to a collections agency, and/or**
- **A claim will be filed in small claims court or civil court**

By law, we will provide emergency services to you on a cash-only basis for the next 30 days. You must then arrange to have medical services elsewhere. Please have your new provider's office contact us for a copy of your medical records.

Sincerely,

[Insert your name here]
[Insert your practice name]