

[insert date]

[insert address]

SENT VIA CERTIFIED MAIL/RETURN RECEIPT REQUESTED

RE: [insert patient name], [insert patient DOB]

Dear [insert patient name]:

As we discussed during our conversation on [insert date], I am writing to request that you seek care from another physician due to nonpayment of your bill with this practice. We have attempted to advise you of the situation on multiple occasions, but to date, we have not received payment. In my carefully considered opinion, you will be better served to obtain care from another medical provider.

Please be advised that as of the date of this letter, I will no longer be available to provide you with medical care and treatment. Therefore, for the next thirty (30) days, I will provide only urgent medical care for you. You can obtain the names of other physicians by contacting your local medical society or local hospital. If you have a medical insurance plan, the plan administrator will direct you to other physicians who may be willing to assume your care. In addition, you can refer to the yellow pages for the contact information of such physicians. While your medical conditions are stable and this transfer of care will have no negative impact on your health, I encourage you to immediately call the provider of your choice and make proper arrangement for your ongoing care.

My office will forward a copy of your medical records to your new physician upon request and written authorization. We have enclosed a release of medical information authorization form for your convenience. If you have any questions regarding the authorization or this notice, please do not hesitate to contact my office at [insert phone number].

Sincerely,

Enclosure