central indiana podiatry, pc

termination FOR NON-PAYMENT Notice

Certified Mail # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recipient Name

Street Address

City, ST ZIP Code

Date

Dear Recipient,

On (date), I sent you a letter requesting you contact the Billing Specialist or me regarding any problems that may have occurred resulting in non-payment of your account. In the letter, I stated that it would be necessary to terminate our physician/patient relationship if we did not hear from you.

Since we have not heard from you, please be advised that I will no longer be able to treat you as a patient. The termination of our relationship will be effective in 30 days from the date of this letter.

A release form is enclosed for your written authorization, allowing us to forward your medical record to the physician of your choice. Please provide the completed release to your new physician. Your account will be closed.

Sincerely,

Physician