# Patient Collection Letter

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Billing Phone Number)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Re: Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account #:

Balance Due: $

Dear PATIENT,

This is to notify you that your account with us is delinquent. We have not received a response to the statements that were sent to you. The patient balance noted above is the amount that is your responsibility after your insurance company has made payments.

We must receive your payment within 15 days from the date of this letter, to avoid further collection action.

If you need assistance or have any questions, please call between the hours of 8 a.m. and 5 p.m. If you are unable to pay this bill in full, please call and we can discuss setting up a payment plan.

Sincerely,

Patient Accounts