SAMPLE REMINDER LETTER

Date:

John Doe
Address
City, State, Zip Code

Dear Mr. Doe,

This letter is to remind you of your outstanding balance in the amount of $ _____. Please remit this balance within ten (10) days or contact our office at _____ to advise us when we can expect to receive your payment or if you would like to make other financial arrangements with us.

As a courtesy to our patients, we do accept MASTER CARD AND VISA. If you choose to pay your balance with this option, simply complete the form at the bottom, sign and return this letter to our office.

If you have already mailed your payment, please accept our thanks and apologies for any inconvenience this may have caused.

Sincerely,

Patient Account Coordinator

❑ **MASTER CARD** ❑ **VISA**

Card # _____ Expiration Date _____

Cardholder's Signature _____ Date _____

Cardholder's Name _____Amount $ _____

SAMPLE COLLECTION LETTER

Date:

John Doe
Street Address
City, State, Zip Code

Dear Mr. Doe,

On (date reminder letter sent), I informed you of your outstanding balance. To date, I have not received payment for this balance nor have you contacted me to discuss your account.

Please contact our office as soon as possible so we do not have to continue further collection efforts. I hope you will act promptly by forwarding to us your payment in full immediately or by contacting me to discuss other financial arrangements.

My phone number is _____.

I look forward to resolving this matter soon.

Sincerely,

Patient Account Coordinator

SAMPLE PATIENT AGREEMENT

PATIENT NAME _____ ACCOUNT # _____

In consideration of an extension of credit granted to (name) ___, as a patient of (physician) _____, agrees to pay the sum of $_____ per month to be applied toward the outstanding balance of $ __.

This amount is due on the _____ of each month, beginning (date) _____ and will continue until final payment is made on (date) _____.

I understand if I fail to make these scheduled payments, my account will be turned over to an outside collection agency.

SIGNATURE _____ DATE _____

___

PRINT NAME _____

WITNESS_____DATE_____

___

RELATIONSHIP TO PATIENT _____

___