

# Therapeutic Appointment Verification

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Provider Name: [Insert Provider Name]

Provider Contact: [Insert Provider Contact Information]

Appointment Date: [Insert Appointment Date]

Appointment Time: [Insert Appointment Time]

Location: [Insert Appointment Location]

Thank you for confirming your appointment. If you have any questions or need to reschedule, please contact us at the number listed above.

Best regards,

[Insert Your Name]

[Insert Your Title]

[Insert Clinic/Practice Name]