

# Termination of Patient Care Agreement

Date: [Insert Date]

[Patient's Name]

[Patient's Address]

[City, State, Zip Code]

Dear [Patient's Name],

We are writing to formally inform you that your patient care agreement with us, dated [Insert Date of Agreement], will be terminated effective [Insert Termination Date].

This decision has been made due to [Insert Reason - e.g., "non-compliance with treatment plan"]. We encourage you to seek alternative healthcare providers to ensure continuity of care.

Please ensure that all pending invoices are settled by [Insert Deadline]. If you have any questions or require further assistance, do not hesitate to contact our office.

Thank you for allowing us to be part of your healthcare journey.

Sincerely,

[Your Name]

[Your Title]

[Practice Name]

[Contact Information]