

[Your Name/Company Name]  
[Address Line 1]  
[City, State, Zip Code]  
[Phone Number]

[Date]

[Patient Name]  
[Patient Address Line 1]  
[City, State, Zip Code]

**RE: NOTICE OF OVERDUE BALANCE**

Account Number: [Account Number]  
Date of Service: [Date of Service]  
Patient Name: [Patient Name]  
Total Amount Due: \$[Amount]

Dear [Patient Name],

Our records indicate that we have not yet received payment for healthcare services provided on [Date of Service]. This balance is now past due.

Please remit the full payment of \$[Amount] by [Due Date] to ensure your account remains in good standing. You may pay by mail, by calling our office, or through our online portal at [Website URL].

If you have already sent your payment, please disregard this notice. If you believe there is an error regarding this bill or if your insurance information has changed, please contact our billing department immediately at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Department Name]  
[Company Name]