[Hospital or Clinic Name]
[Billing Department Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

**RE: NOTICE OF PAST DUE BALANCE**

Account Number: [Account Number]
Invoice Number: [Invoice Number]
Patient Name: [Patient Name]
Date of Service: [Date of Service]

Dear [Patient Name],

Our records indicate that your account is now thirty (30) days past due. According to our files, there is an outstanding balance of $[Amount Due] for medical services provided on [Date of Service].

If you have already sent your payment, please disregard this notice and accept our thanks. If you have not yet made a payment, please remit the full amount by [Due Date] to ensure your account remains in good standing.

**Payment Options:**

- **Online:** Visit [Website URL] and use your account number to pay via credit card or bank transfer.
- **By Mail:** Send a check or money order to the address listed above. Please include your account number on the check.
- **By Phone:** Call our billing department at [Phone Number] to pay over the phone.

If you are experiencing financial hardship or cannot pay the full amount at this time, please contact us immediately. We offer various payment plans and financial assistance programs that may be available to you.

If you believe this bill is in error or if you have questions regarding your insurance coverage, please contact our billing office at [Phone Number] between [Hours of Operation].

Sincerely,

[Name/Department]
[Hospital or Clinic Name]