**<Insert physician name(s), office/clinic logo, other contact information and date>**

|  |
| --- |
| **PATIENT INFORMATION** |
| Patient Name |
| Patient DOB |
| **SERVICE REQUESTED** |
|  |

|  |  |
| --- | --- |
| **FILE / INVOICE #** | **DATE** |
|  |  |

Dear **<Insert name of third party>**:

I am in receipt of your request for the completion of the service noted above.

This letter is intended to inform you of my standard fee for the provision of this service, which is based on the Ontario Medical Association’s suggested rate listed in the **<insert year>** edition of the Physician’s Guide to Uninsured Services.

The estimated fee for this service is **<enter $ figure (and itemized breakdown, where appropriate)>**. This figure assumes no extraordinary complexity and/or follow-up information requests for clarification or additional information. Should such follow-up work be required, additional estimates will be provided in a similar fashion.

An invoice will be sent to you upon completion of the service. **<Insert any policy related to timeframe of expected payment and/or interest charges for late payments>**

Please acknowledge receipt and acceptance of this estimate and policy by signing below and providing a copy by fax, mail or via email to **<insert email address>**. Should you have any further questions, please contact **<insert name of office staff person>** at **<insert phone number or email address>.**

Sincerely

**<Insert name and signature>**

**I agree with the above estimate and terms/conditions of payment.**

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Name Company/Organization Date**