Confirmation of Third Party Request

PATIENT INFORMATION
Patient Name
Patient DOB
SERVICE REQUESTED

FILE / INVOICE #	DATE

Dear :

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 edition of the Physician's Guide to Uninsured Services.

The estimated fee for this service is .
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.

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Please acknowledge receipt and acceptance of this estimate and policy by signing below and providing a copy by fax, mail or via email to . Should you have any further questions, please contact at

.

Sincerely

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

_____ _____ _____

Name **Company/Organization** **Date**