

# FINAL NOTICE BEFORE LEGAL ACTION

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Demand is hereby made for payment of the sum of \$\_\_\_\_\_. You must notify this office immediately if you believe your balance is in error.

Failure to pay within ten (10) days of the date of this notice will result in prompt legal action to enforce collection, along with interest, attorney fees and collection costs.

YOU WILL RECEIVE NO FURTHER NOTICE

Name of Dental Practice: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

To reorder call 800-427-2830

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