

[Provider Entity Name]/[Portrait Medical Group Entity]  
[Address of Provider Entity]

[Date]

[Patient Name and Address]

Dear [Patient Name]:

I have received your request for a refund for the fees you paid for your treatment on [DATE]. As [provider name] discussed with you before the treatment, and consistent with the informed consent you signed, [side effect/condition] is a known risk of [treatment name].

It is unfortunate that [this occurred/you are not happy with the results], but I have reviewed your patient record, and all treatment you received was appropriate. However, I understand that you are dissatisfied with the treatment and for this reason, and as a patient courtesy, a partial refund of the professional fees in the amount of \$[dollar amount] will be refunded to you via [check/refund to cc/something else?].

Please complete the attached Refund General Release in order to receive the refund. I am pleased that we could agree on this matter. Please feel free to contact me at [contact info - could be email or phone number] if you have any questions.

Sincerely,

Patrick Blake, M.D.  
Chief Medical Officer, Portrait

**Refund General Release**

The patient, [Insert Patient Name], will hold harmless and indemnify the provider, [Insert Provider name], [Provider Entity], [Portrait Medical Group], and Portrait Health Inc., and all other involved persons and their successors (the "Released Parties") against any claims and actions, including future claims and actions, in exchange for \$[insert dollar amount] (the "Release").

The patient, [Insert Patient Name], hereby releases the Released Parties from any and all claims and liabilities arising from treatment and/or services provided by the Released Parties from the period of time \_\_\_\_\_ to \_\_\_\_\_.

I make this decision of my own free will relying upon my knowledge and judgment of any injury or outcome I may have sustained during treatment and my decision to release has not been affected by any false statements or representations pertaining to that injury or outcome.

I understand that this action is a business decision and agree this represents a compromise regarding a dispute between the patient and the Released Parties. Accordingly, this refund is not an admission of any liability regarding any Released Party.

I additionally understand that in accepting this Release, I will no longer be a patient of [Provider Entity] and [Portrait Medical Group]. Further, the terms and conditions of this settlement are to be kept confidential and will not be disclosed to any other party in the future.

I have carefully read this Release and understand its contents, and I am signing it of my own free act.

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

Patient Name: [Insert Patient Name]

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