



# TOOLKIT FOR A PLANNED CLOSING OF YOUR PRACTICE

*Special supplement to*  
**THE CARLAT REPORT**  
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## **About This Resource**

This toolkit is designed for psychiatrists who are planning to close a practice, usually as part of a retirement plan. These tools will help you to organize materials and information needed for a successful practice closure. Having this information in one place will be particularly helpful if you plan to delegate some or all of these tasks to an assistant or other staff member. Section 10 of this toolkit includes templates of letters and other closure materials.

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[www.psychiatry.org/join-apa/general-members](http://www.psychiatry.org/join-apa/general-members).

# Checklist for Closing a Practice

## 1. Notify patients

- A. Post a notice in your office and on your website (if you have one) about the date you will be closing your practice, and include other important details for patients.
- B. During regular appointments, tell your patients about your retirement plans, and give them a handout with information about where they can go for continuation of their care.
- C. Contact other active patients (who do not have any scheduled appointments) by mail or email. (See practice closing letter template.)

## 2. Notify agencies, institutions, and associations

- A. Inform your state medical board(s). In many states, you will be able to do this online. Check your state medical board's website for details.

The telephone number(s) for the state medical board(s) where I am licensed to practice medicine:

State	Telephone Number	License Number	Expiration

- B. Notify the DEA and your state's department of public health. Visit the DEA registration page for more details ([www.deadiversion.usdoj.gov/drugreg/index.html](http://www.deadiversion.usdoj.gov/drugreg/index.html)).

**Federal DEA office contact information:** \_\_\_\_\_

**DEA certificate number:** \_\_\_\_\_

**State department of public health contact information:** \_\_\_\_\_

- C. Notify hospitals and/or clinics with which you are affiliated.

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

D. Notify third-party payers.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**3. Dispose of medication samples and prescription blanks**

Contact the DEA regarding what to do with medication samples and prescription blanks. Visit the DEA Registrant Drug Disposal page for more details ([www.dea diversion.usdoj.gov/drug\\_disposal/index.html](http://www.dea diversion.usdoj.gov/drug_disposal/index.html)).

**4. Notify your billing company**

Ensure that all remaining financial obligations, including those to vendors, patients, and insurance companies, are covered.

My billing is handled by:

Me                       Staff                       Billing service

The staff person who coordinates my billing is: \_\_\_\_\_

My billing service is: \_\_\_\_\_

Telephone number: \_\_\_\_\_

**5. Notify businesses to terminate accounts**

(Not all these services will apply to your practice; amend as needed.)

My business records are kept [specify filing cabinet or provide access credentials if you store these records electronically]

Service Provider	Company Name	Account #	Contact Name	Contact #
Business phone				
Business cell phone				
Business fax				
Internet provider				
Copier				

Computer				
Office supplies				
Premises lease				
Insurance agent (property/life/workers' comp/disability, etc)				
Attorney				
Electricity supply				
Oil/gas supply				
Water supply				

**6. Notify medical malpractice carrier**

Name/contact of company: \_\_\_\_\_

Type of insurance: \_\_\_\_\_

**7. Notify financial vendors**

Service Provider	Company Name	Account #	Contact Name	Contact #
Practice bank account				
Financial advisor (investments/ retirement)				
Practice accountant				
Payroll service				

**8. Notify and terminate professional memberships/responsibilities**

Activity	Company/Personal Contact Name	Membership # or Account #	Contact Telephone #	Comments
Professional association(s), specialty boards (eg, ABPN)				
Journal(s)/ subscription(s)				
Teaching responsibilities				
Other regular clinical/professional commitments				

**9. Coordinate access to patient records**

[Provide location of patient charts, whether in paper or electronic form]

When you receive requests for records, copy them and send them to the professional office or to the patient who is making the request. Charge \$XX for administrative services.

**10. Use sample letters, voice mails, and/or email announcements for notifications**

The following are sample letters your administrator can customize for use.

**Sample Letter to Business**

Dear \_\_\_\_\_:

RE: Account Number: \_\_\_\_\_

Please be advised that as of [date of practice closure] my practice will be permanently closed. Please forward to my attention any outstanding bills for your services to ensure prompt payment.

Thank you for your immediate attention to this request. Should you have any questions or concerns, please feel free to contact me at \_\_\_\_\_.

Sincerely,  
Dr. \_\_\_\_\_

**No Further Mail Letter**

Dear \_\_\_\_\_:

RE: AccountNumber/Membership Number: \_\_\_\_\_

Please terminate the membership/journal \_\_\_\_\_ for Dr. \_\_\_\_\_. I will no longer be practicing as of [date of practice closure].

Thank you for your immediate attention. Should you have any questions or concerns, please feel free to contact me at \_\_\_\_\_.

Sincerely,

Dr. \_\_\_\_\_

**Sample Letter to Patients After Emergency Office Closure**

I plan to retire from practice of psychiatry on \_\_\_\_\_ .

It is important that you continue to receive appropriate treatment. Several options for follow-up treatment are listed below:

[Adapt for your practice]

Since the records of your case are confidential, we will require your written authorization to release your information to another physician, or to you. For this reason, I am enclosing an authorization form. Please complete the form and return to the address listed. There will be a charge of \_\_\_\_\_ for copying records to cover practice expenses. If you do not return this authorization form by \_\_\_\_\_, you should contact the \_\_\_\_\_ [records company] for further assistance.

Please note that after \_\_\_\_\_ there will no longer be anyone at this number to answer your call. If you need assistance after this date, please contact one of the doctors on the attached list, who will assist you to find someone to continue your treatment. Alternatively, you may contact your health care insurers for a list of other providers in your coverage/plan area.

We recognize that changing your physician may be stressful. We encourage you to seek continuity by accessing a replacement physician.

Sincerely,

Office Manager/Special Administrator

**Voice Mail/Email Announcement**

(The following message can be tailored for either an “out of office” message or an answering service.)

Hello, you have reached the office of Dr. \_\_\_\_\_. As of [date of closure], I have retired and am no longer seeing patients.

If you have a clinical emergency, please dial 911 or go to your nearest emergency room.

If you need assistance with a prescription refill, please contact Dr. \_\_\_\_\_ at \_\_\_\_\_.

If you are a patient of mine seeking a referral for ongoing treatment, please visit my website at \_\_\_\_\_ for a list of referrals.

Thank you.