

Payment Plan Agreement for Medical Expenses

Date: [Insert Date]

To: [Patient's Name]

Address: [Patient's Address]

Email: [Patient's Email]

Phone: [Patient's Phone Number]

Dear [Patient's Name],

We are writing to outline the structured payment plan for your medical expenses totaling [Insert Total Amount]. In order to accommodate your financial situation, we have proposed the following payment schedule:

Payment Plan Details

- Total Amount Due: [Insert Total Amount]
- Down Payment: [Insert Down Payment Amount]
- Monthly Payment Amount: [Insert Monthly Payment Amount]
- Number of Payments: [Insert Number of Payments]
- Payment Due Date: [Insert Due Date for Each Payment]

Payments can be made via [Insert Payment Method Options] and should be sent to [Insert Payment Address or Account Details]. Please ensure that all payments are made on or before the due date specified above.

If you have any questions or require further assistance regarding this payment plan, please do not hesitate to contact us at [Insert Contact Information].

Thank you for choosing [Insert Medical Facility Name] for your healthcare needs.

Sincerely,

[Your Name]

[Your Position]

[Medical Facility Name]

[Medical Facility Address]

[Medical Facility Phone Number]