Patient Payment Plan Agreement Proposal

Date: _____

To: [Patient's Name]

Address: [Patient's Address]

Dear [Patient's Name],

We are committed to providing you with the highest quality of care. To help you manage your medical expenses, we would like to propose a payment plan that suits your financial situation.

Payment Plan Details:

- Total Amount Due: $[Total Amount]
- Initial Payment: $[Initial Payment Amount]
- Payment Frequency: [Weekly/Monthly]
- Number of Installments: [Number of Payments]
- Due Date for Each Installment: [Due Date]

Please review the proposed payment plan, and if you agree to the terms, please sign below and return a copy to our office.

Agreement:

By signing below, you agree to the terms outlined in this payment plan proposal.

_____

Patient's Signature

_____

Date

If you have any questions or would like to discuss this further, please do not hesitate to contact our office at [Office Phone Number].

Thank you for choosing [Your Practice's Name].

Sincerely,

[Your Name]

[Your Title]

[Your Practice's Name]

[Contact Information]