Payment Plan Agreement for Outstanding Medical Fees

Date: [Insert Date]

To: [Patient's Name]

[Patient's Address]

[City, State, Zip Code]

Dear [Patient's Name],

We hope this letter finds you in good health. We are writing to discuss your outstanding medical fees, totaling [Insert Amount]. In order to assist you in managing this balance, we would like to propose a structured payment plan.

Proposed Payment Plan:

1. Initial Payment: [Insert Amount] due by [Insert Date]
2. Subsequent Payments: [Insert Amount] due monthly on the [Insert Day] of each month for [Insert Duration].

Please note that the total balance must be settled by [Insert Final Payment Date]. Any missed payments may result in additional fees or collection actions.

To accept this payment plan, please sign and return a copy of this letter. Should you have any questions or require adjustments to your payment plan, feel free to contact us at [Insert Phone Number] or [Insert Email Address].

Thank you for your attention to this matter. We appreciate your cooperation and look forward to assisting you.

Sincerely,

[Your Name]

[Your Title]

[Medical Facility Name]

[Contact Information]