Payment Plan Agreement for Healthcare Costs

Date: [Insert Date]

To: [Patient's Name]

Address: [Patient's Address]

Dear [Patient's Name],

We are writing to confirm your tailored payment plan agreement for your healthcare costs incurred at [Healthcare Provider's Name]. This agreement outlines the terms and conditions for the payment of your outstanding balance.

Payment Plan Details

- Total Amount Due: $[Total Amount]
- Initial Payment: $[Initial Payment] due by [Due Date]
- Monthly Installment: $[Monthly Installment] for [Number of Months]
- Payment Due Date: On or before the [Due Date] of each month

Payment Methods

You may make payments via the following methods:

- Online through our patient portal
- By mail via check or money order
- In person at our billing department

Failure to comply with this payment agreement may result in additional fees or collection actions. We highly encourage you to contact us if you have any concerns or need to discuss adjustments to your payment plan.

Thank you for your attention to this matter. We appreciate your cooperation.

Sincerely,

[Your Name]

[Your Title]

[Healthcare Provider's Name]

[Healthcare Provider's Contact Information]