Debt Acknowledgment Receipt

Date: _____

Patient Name: _____

Patient Address: _____

Account Number: _____

To: [Healthcare Provider's Name]

[Healthcare Provider's Address]

Dear [Healthcare Provider's Name],

This letter serves as a formal acknowledgment of the outstanding medical bill for services rendered to me on **[Date of Service]**.

The total amount due is **[$Amount]**. I acknowledge that I am responsible for this amount and agree to make payments as follows:

- Payment Amount: _____
- Payment Due Date: _____
- Payment Method: _____

Please find enclosed my first payment of **[$Payment]** as part of the agreed payment plan.

Thank you for your attention to this matter. I look forward to resolving this debt promptly.

Sincerely,

[Your Name]

[Your Signature]

[Your Contact Information]