Debt Reaffirmation Agreement

Date: [Insert Date]

To: [Creditor's Name]
Address: [Creditor's Address]
City, State, Zip: [Creditor's City, State, Zip]

From: [Your Name]
Address: [Your Address]
City, State, Zip: [Your City, State, Zip]
Phone: [Your Phone Number]

Subject: Reaffirmation of Debt

Dear [Creditor's Name],

I am writing to reaffirm my commitment to pay the medical bills outlined below. I understand the importance of repaying this debt and wish to formalize my agreement to do so.

Account Number	Amount Owed	Service Date
[Account Number]	[Amount Owed]	[Service Date]

I agree to make payments as follows:

- Payment Amount: [Insert Amount]
- Payment Schedule: [Insert Schedule]

Please acknowledge receipt of this letter and confirm your acceptance of this reaffirmation agreement.

Thank you for your understanding and cooperation.

Sincerely,

[Your Name]
[Your Signature (if sending a hard copy)]