Agreement for Monthly Payment of Medical Expenses

Date: ____________

Between:

Patient's Name: ________________________

Address: ________________________

And:

Medical Provider's Name: ________________________

Address: ________________________

Agreement Terms

1. The Patient agrees to pay the Medical Provider a monthly payment of $__________ for medical expenses incurred from ___________ to ___________.

2. Payments are due on the _____ day of each month.

3. Delayed payments will incur a late fee of $__________ after _____ days.

4. The Patient has the right to review and dispute charges within _____ days of receiving a bill.

Signature

By signing this agreement, both parties acknowledge and accept the terms stated above.

__________________________ **Patient's Signature** Date: ____________

__________________________ **Provider's Signature** Date: ____________