Deferred Payment Agreement

Date: **[Insert Date]**

[Patient's Name]
[Patient's Address]
[City, State, ZIP Code]

[Healthcare Provider's Name]
[Healthcare Provider's Address]
[City, State, ZIP Code]

Subject: Deferred Payment Agreement for Medical Bills

Dear [Healthcare Provider's Name],

I am writing to formally request a deferred payment agreement regarding my outstanding medical bills from [date(s) of service]. As of today, my total outstanding balance is **$[Total Amount]**.

Due to [brief explanation of financial hardship], I am unable to pay this amount in full at this time. However, I am committed to settling this debt and would like to propose a payment plan as follows:

- Amount of each payment: **$[Proposed Payment Amount]**
- Payment frequency: **[Weekly/Bi-weekly/Monthly]**
- Start date for payments: **[Insert Start Date]**
- Duration of the payment plan: **[Insert Duration]**

I kindly ask for your understanding and cooperation in this matter. Please let me know if you are agreeable to this arrangement or if you need any further information from my side.

Thank you for your attention to this matter, and I look forward to your positive response.

Sincerely,

[Your Name]
[Your Contact Information]