Payment Plan Agreement

Date: _____

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Provider Name: _____

Provider Address: _____

City, State, Zip: _____

Agreement

This Payment Plan Agreement ("Agreement") is made between the above-named Patient and Provider for the payment of medical expenses incurred by the Patient.

Payment Details:

Total Amount Due: $_____

Initial Payment: $_____ due by _____

Monthly Payment Amount: $_____

Payment Due Date: The monthly payments will be due on the _____ day of each month.

Final Payment Date: The remaining balance will be paid in full by _____.

Terms and Conditions:

- Payments can be made via cash, check, or credit card.
- If a payment is missed, a late fee of $_____ will be charged.
- This agreement is binding upon both parties and may be modified only with written consent.

Signatures:

_____

Patient Signature

Date: _____

_____

Provider Signature

Date: _____