Healthcare Bill Payment Plan Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Account Number: [Insert Account Number]

Dear [Patient Name],

We understand that healthcare costs can sometimes be overwhelming. In order to assist you, we are pleased to offer a payment plan for your outstanding balance totaling [Insert Total Amount]. Below are the details of your payment plan agreement:

Payment Plan Details

- Total Amount Due: [Insert Total Amount]
- Down Payment Required: [Insert Down Payment Amount]
- Number of Installments: [Insert Number]
- Installment Amount: [Insert Installment Amount]
- Due Date for Each Installment: [Insert Due Dates]

By signing this agreement, you agree to the terms of the payment plan as outlined above. Please return a signed copy of this agreement by [Insert Return Date].

Patient Agreement

Patient Signature: _____

Date: _____

Thank you for choosing [Healthcare Provider Name]. We appreciate your dedication to managing your healthcare expenses.

Sincerely,

[Your Name]
[Your Title]
[Healthcare Provider Name]
[Contact Information]