Healthcare Payment Plan Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Provider Name: [Insert Provider Name]

Provider Address: [Insert Provider Address]

Re: Payment Plan Agreement for Elective Procedure

Dear [Insert Patient Name],

This letter serves as a formal agreement between **[Provider Name]** and **[Patient Name]** regarding the financing of the elective procedure scheduled on [Insert Date of Procedure].

1. Procedure Details

Procedure Description: [Insert Procedure Description]

Total Cost: $[Insert Total Cost]

2. Payment Plan

The payment plan will consist of [Insert Number of Payments] monthly installments of $[Insert Payment Amount] each.

The first payment will be due on [Insert Due Date] and subsequent payments will be due on the same day of each following month.

3. Payment Methods

Payments can be made via [Insert Accepted Payment Methods].

4. Late Payments

A late fee of $[Insert Late Fee Amount] will be applied if a payment is not received within [Insert Grace Period] days of the due date.

5. Agreement Acceptance

By signing below, both parties agree to the terms outlined in this payment plan agreement.

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[Patient Name] - Patient Signature

Date: _________________________

____

[Provider Name] - Provider Signature

Date: _________________________

Thank you for choosing [Provider Name] for your healthcare needs. We look forward to providing you with excellent care.

Sincerely,

[Provider Name]

[Provider Title]

[Provider Contact Information]