Healthcare Payment Plan Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

City, State, Zip: [Insert City, State, Zip]

Phone Number: [Insert Phone Number]

Dear [Patient Name],

We understand that medical expenses can be overwhelming. In response to your recent inquiry regarding a payment plan for your outstanding medical bills, we are pleased to offer you the following agreement:

Payment Plan Agreement

Total Amount Due: $[Insert Total Amount]

Proposed Payment Plan:

- Initial Payment: $[Insert Initial Payment Amount] due by [Insert Due Date]
- Monthly Payments: $[Insert Monthly Payment Amount] for [Insert Number of Months] months due on the [Insert Due Day] of each month

If you agree to this payment plan, please sign and return this letter to us by [Insert Return Date].

Terms and Conditions

[Insert any specific terms and conditions related to the payment plan]

Acceptance

By signing below, you agree to the terms of the payment plan:

_____

Signature of Patient

Date: _____

Thank you for your attention to this matter. We look forward to assisting you in managing your healthcare expenses.

Sincerely,

[Insert Your Name]

[Insert Your Position]

[Insert Healthcare Provider Name]

[Insert Contact Information]