Healthcare Payment Plan Agreement

Date: _____

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Dear [Patient Name],

We understand that healthcare costs can be a burden, especially for low-income families. Therefore, we are pleased to offer you a payment plan to assist with your healthcare expenses.

Payment Plan Details

Total Amount Due: $_____

Initial Deposit: $_____ (due upon signing)

Payment Installments: $_____ (due monthly)

Payment Due Date: _____ (monthly on the ___ day)

Terms and Conditions

- This agreement is valid for [duration].
- Payments can be made via [payment methods].
- Failure to adhere to the payment schedule may result in [consequences].

By signing below, you agree to the terms and conditions of this payment plan.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Thank you for choosing us for your healthcare needs. We are here to support you.

Sincerely,

[Healthcare Provider Name]

[Contact Information]