Healthcare Payment Plan Agreement

Date: _____

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Email: _____

Phone Number: _____

Provider Name: _____

Provider Address: _____

City, State, Zip: _____

Agreement Details

This Agreement is made by and between **[Provider Name]** and **[Patient Name]** regarding the payment plan for the ongoing treatment expenses incurred by the patient.

Payment Plan Terms:

- Total Amount Due: $_____
- Initial Payment: $_____ due on _____.
- Monthly Payment Amount: $_____.
- Number of Monthly Payments: _____.
- Payment Due Date: _____ for each subsequent payment.

Conditions:

1. Payments must be made on or before the due date to avoid any late fees.

2. Late payments may incur a fee of $_____.

3. In the event of financial hardship, the patient must notify the provider to discuss possible adjustments.

Signatures:

By signing below, both parties agree to the terms outlined in this Payment Plan Agreement.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____