Healthcare Payment Plan Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Patient Contact: [Insert Patient Contact]

Agreement Overview

This Healthcare Payment Plan Agreement is made between [Healthcare Provider Name], hereafter referred to as "Provider," and [Patient Name], hereafter referred to as "Patient."

Payment Plan Details

- Total Amount Due: [Insert Total Amount]
- Monthly Payment Amount: [Insert Monthly Payment Amount]
- Number of Installments: [Insert Number of Payments]
- Payment Due Date: [Insert Due Date Each Month]

Terms and Conditions

1. The Patient agrees to make payments as outlined above until the total amount is paid in full.

2. Late payments may incur additional fees as per the Provider's policy.

3. The Patient is responsible for notifying the Provider of any changes in their contact information or financial status.

Signature

By signing below, both parties agree to the terms of this payment plan.

_____
Patient Signature
Date: [Insert Date]

_____
Provider Signature
Date: [Insert Date]