Healthcare Payment Plan Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Address]

Account Number: [Insert Account Number]

Dear [Patient Name],

We understand that you may be experiencing financial hardship, and we want to ensure that you receive the medical care you need while addressing your financial concerns. To assist you, we are pleased to offer a payment plan agreement for your outstanding balance.

Payment Plan Details:

- Total Amount Due: $[Insert Amount]
- Initial Payment Due: $[Insert Amount] (Due by [Insert Due Date])
- Subsequent Payments: $[Insert Amount] per month
- Payment Frequency: Monthly
- Payment Due Date: [Insert Due Date each month]

Please review this agreement and confirm your acceptance by signing below. If you have any questions or require further assistance, feel free to contact our office at [Insert Phone Number] or [Insert Email Address].

Agreement Acceptance:

I, [Insert Patient Name], agree to the payment plan as outlined above.

Signature: _____

Date: _____

Thank you for choosing [Insert Healthcare Provider Name]. We are here to support you.

Sincerely,

[Insert Healthcare Provider Name]

[Insert Contact Information]