Healthcare Payment Plan Agreement

Date: _____

Recipient Name: _____

Address: _____

City, State, Zip: _____

Dear [Recipient Name],

This letter serves as a formal agreement regarding a healthcare payment plan for the medical services rendered on [date of service]. We understand the importance of accessible healthcare for our senior citizens and aim to provide a manageable payment solution.

Payment Plan Details

- Total Amount Due: $_____
- Initial Payment: $_____
- Monthly Payment Amount: $_____
- Number of Payments: _____
- Payment Due Date: _____ of each month

Please sign below to confirm your acceptance of this payment plan:

_____

Signature of Recipient

Date: _____

Terms and Conditions

1. Payments are to be made by [payment methods accepted].

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

3. For any changes in the payment plan, please contact our office at [phone number].

Thank you for allowing us to assist you with your healthcare needs.

Sincerely,

[Your Name]

[Your Title]

[Healthcare Provider's Name]

[Contact Information]