Healthcare Payment Plan Agreement

Date: _____

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Introduction

This Payment Plan Agreement ("Agreement") is entered into between [Healthcare Provider Name] and the Patient named above for the provision of transitional care services.

Payment Plan Terms

1. Total Cost of Services: $_____

2. Initial Payment Due: $_____ (Due by: _____)

3. Monthly Payment Amount: $_____

4. Total Number of Payments: _____

5. Payment Due Date: _____ of each month

Payment Methods

Payments may be made via the following methods:

- Credit/Debit Card
- Check
- Electronic Funds Transfer

Cancellation Policy

Patient may cancel this agreement by providing written notice to [Healthcare Provider Name] at least [number] days prior to the next scheduled payment.

Agreement Signatures

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

_____

Patient Signature

Date: _____

_____

Provider Signature

Date: _____