Healthcare Payment Plan Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Address: [Insert Patient Address]

Account Number: [Insert Account Number]

Agreement Overview

This payment plan is designed to provide financial assistance to uninsured patients for the medical services rendered by [Hospital/Clinic Name].

Payment Plan Details

Total Amount Due: $[Insert Total Amount]

Down Payment: $[Insert Down Payment]

Monthly Payment Amount: $[Insert Monthly Payment]

Number of Installments: [Insert Number of Installments]

Start Date of Payment Plan: [Insert Start Date]

Due Date for Monthly Payments: [Insert Due Date]

Terms and Conditions

- Payments must be made on or before the due date.
- If the payment is not received by the due date, a late fee of $[Insert Late Fee] may be applied.
- Failure to comply with this agreement could result in collection actions.

Patient Agreement

By signing below, I acknowledge that I have read and understood the terms of this payment plan agreement and agree to adhere to the outlined conditions.

Patient Signature: _____

Date: _____

Contact Information

If you have any questions regarding this agreement, please contact:

[Hospital/Clinic Name]

Phone: [Insert Phone Number]

Email: [Insert Email Address]