

[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: Confirmation of Repayment Schedule - Account #[Account Number]

Dear [Patient Name],

This letter serves as formal confirmation of the debt repayment agreement discussed between you and [Clinic Name] regarding your outstanding balance of \$[Total Balance Amount].

As agreed, your repayment schedule is as follows:

- **Total Debt Amount:** \$[Amount]
- **Installment Amount:** \$[Amount] per month
- **Number of Payments:** [Number] months
- **Start Date:** [Date of First Payment]
- **Due Date:** [Day of the month, e.g., 5th of every month]

Please make your payments via [Payment Method: e.g., Online Portal, Check, or Phone].

By following this schedule, no further collection actions will be taken. Please notify our billing department at [Phone Number] immediately if you experience any financial changes that may prevent you from making a scheduled payment.

Thank you for your prompt attention to this matter.

Sincerely,

[Name of Billing Representative]
[Title]
[Clinic Name]