[Date]

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

Re: Account Number: [Account Number]
Total Balance Due: $[Total Amount]

Dear [Patient Name],

This letter serves as formal confirmation of the installment payment agreement reached regarding your delinquent medical account with [Medical Provider/Facility Name].

We have agreed to the following payment schedule to resolve your outstanding balance:

- **Monthly Payment Amount:** $[Amount]
- **Due Date:** [Day of Month, e.g., 15th] of each month
- **Start Date:** [Date of First Payment]
- **Number of Installments:** [Number]

Payments can be made via [Payment Methods: Online/Check/Phone]. Please ensure that your account number is included with every payment to ensure proper credit.

Please be advised that this agreement is contingent upon timely payments. If a payment is missed or late, the full remaining balance may become due immediately, and the account may be subject to further collection actions.

If you have any questions or if your financial situation changes, please contact our billing department at [Phone Number] as soon as possible.

Sincerely,

[Your Name/Signature]
[Title]
[Medical Provider/Facility Name]