

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Account Number: [Account Number]

Dear [Patient Name],

This letter is to formally notify you that [Healthcare Provider Name] has accepted your request for a monthly payment plan regarding your outstanding balance of \$[Total Amount Owed].

The agreed-upon terms of your payment plan are as follows:

- **Monthly Payment Amount:** \$[Amount]
- **Payment Due Date:** [Day] of each month
- **Start Date:** [Date of First Payment]
- **Number of Installments:** [Total Number of Payments]

Payments can be made via [Payment Method: e.g., Online Portal, Check, or Phone]. Please ensure that your account number is included with every payment to ensure proper credit to your account.

Please note that failure to make scheduled payments on time may result in the cancellation of this agreement and the full balance becoming due immediately. If you experience financial hardship that prevents you from making a payment, please contact our billing department at [Phone Number] as soon as possible.

Thank you for your commitment to resolving this balance.

Sincerely,

[Signature]

[Name of Billing Representative]

[Department Name]

[Healthcare Provider Name]