Date: [Insert Date]

Patient Name: [Insert Patient Name]
Account Number: [Insert Account Number]
Total Balance Due: $[Insert Total Amount]

Dear [Insert Recipient Name],

This letter confirms that [Insert Hospital Name] has approved an installment payment plan for your outstanding medical balance. By entering into this agreement, you agree to the following terms:

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

Please ensure that payments are received by the due date specified above. Payments can be made via [Insert Payment Methods, e.g., online portal, mail, or phone].

Failure to make consecutive payments may result in the cancellation of this agreement and the remaining balance becoming due immediately. If you experience financial hardship and cannot make a scheduled payment, please contact our Billing Department at [Insert Phone Number] as soon as possible.

Thank you for your cooperation in resolving this matter.

Sincerely,

[Insert Name/Department]
[Insert Hospital Name]
[Insert Contact Information]