[Hospital Name]
[Billing Department Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

Re: Payment Plan Confirmation
Account Number: [Account Number]
Total Balance: $[Total Amount]

Dear [Patient Name],

This letter confirms that we have approved your request to pay your outstanding medical balance through an installment program. We have enrolled your account in the following payment plan:

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

Please make checks payable to **[Hospital Name]** and include your account number on the memo line. If you prefer to pay online, please visit [Website URL].

To keep this agreement active, payments must be received on or before the due date each month. If you anticipate any difficulty making a payment, please contact the Billing Department immediately at [Phone Number] to discuss your options.

Failure to make scheduled payments may result in the cancellation of this agreement and the full balance becoming due immediately.

Thank you for your cooperation in resolving this matter.

Sincerely,

[Name of Billing Representative]
Billing Department
[Hospital Name]