[Date]

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

Re: Account Number [Account Number]

Dear [Patient Name],

This letter is to confirm that we have approved your request for an installment payment plan regarding your outstanding medical balance of $[Total Balance Amount].

The terms of your payment plan are as follows:

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

Please make your checks payable to [Medical Facility Name] and include your account number on the memo line. You may also pay online at [Website URL] using your account credentials.

By following this schedule, no further collection actions will be taken. Please note that if a payment is missed, the full remaining balance may become due immediately, and the payment plan may be voided.

If you have any questions or experience financial hardship that prevents you from making a payment, please contact our billing department at [Phone Number] as soon as possible.

Sincerely,

[Name of Billing Representative]
[Title]
[Medical Facility Name]