

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of Collection Agency]
[Address of Collection Agency]
[City, State, Zip Code]

Re: Account Number: [Your Account Number]
Original Creditor: [Name of Hospital/Doctor]
Total Amount Owed: \$[Total Amount]

To Whom It May Concern,

I am writing regarding the medical debt listed above. I would like to resolve this balance, but I am currently unable to pay the full amount in a single payment due to financial constraints.

I am proposing a formal payment schedule of \$[Amount] per month, starting on [Start Date]. I plan to make these payments on the [Day of the Month, e.g., 15th] of every month until the balance is paid in full.

Please note that by making these payments, I am not waiving my right to dispute the validity of this debt or any portion thereof in the future. I request that you send a written agreement confirming that you accept this payment plan and that as long as payments are made on time, this account will not be reported as a "collection" or "delinquent" to the credit bureaus, or that it will be updated to "paid as agreed."

Please send the written confirmation to my address listed above. I will send my first payment once I receive your written acceptance of these terms.

Thank you for your cooperation.

Sincerely,

[Your Signature]

[Your Printed Name]