

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: Approval of Payment Plan for Account #[Account Number]

Dear [Patient Name],

This letter is to formally notify you that your request for a payment plan regarding your outstanding medical balance of \$[Total Amount Owed] has been approved.

The terms of your payment plan are as follows:

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

Payments can be made via [Payment Methods: e.g., online portal, check, or phone]. Please ensure that your account number is included with every payment to ensure it is credited correctly.

Please note that as long as payments are received according to this schedule, your account will remain in good standing and will not be referred to further collection actions. Failure to make a scheduled payment may result in the cancellation of this agreement and the full balance becoming due immediately.

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

Sincerely,

[Your Name/Signature]

[Title]

[Medical Facility/Billing Company Name]