

[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of Billing Department/Collection Agency]
[Name of Medical Institution]
[Address]
[City, State, Zip Code]

RE: Confirmation of Repayment Plan for Account #[Your Account Number]

Dear [Name of Contact Person or Billing Department],

This letter is to formally confirm the debt repayment schedule that we agreed upon regarding my outstanding medical balance for services rendered on [Date of Service].

As per our conversation on [Date of Agreement], I have agreed to pay the total balance of \$[Total Amount Owed] according to the following schedule:

- **Monthly Payment Amount:** \$[Amount]
- **Payment Due Date:** [Day of the month, e.g., 15th] of each month
- **Start Date:** [Date of first payment]
- **Number of Payments:** [Total number of installments]

It is my understanding that as long as I adhere to this payment schedule, my account will remain in good standing and will not be referred to a third-party collection agency or reported negatively to credit bureaus.

Please update your records to reflect this agreement. I would appreciate it if you could send a signed copy of this confirmation or an updated statement showing the installment plan for my records.

Thank you for your cooperation and assistance in resolving this matter.

Sincerely,

[Your Signature]

[Your Printed Name]