

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

[Date]

[Billing Department Name]
[Medical Facility Name]
[Address]
[City, State, Zip Code]

Re: Payment Arrangement for Account Number: [Account Number]
Patient Name: [Patient Name]
Total Balance Due: \$[Total Amount]

To Whom It May Concern,

I am writing regarding the outstanding balance for medical services received on [Date of Service]. I acknowledge my financial responsibility for this bill; however, I am currently unable to pay the full amount in a single payment due to [briefly mention reason, e.g., financial hardship].

I would like to request a formal payment arrangement to clear this balance. I propose to pay \$[Amount] per month, starting on [Start Date]. I intend to continue these monthly payments until the balance is paid in full.

Please let me know if this proposal is acceptable or if there are specific forms I need to complete to finalize this agreement. I would appreciate it if you could send a written confirmation of the agreed-upon payment plan and confirm that this account will not be referred to a collection agency as long as payments are made on time.

Thank you for your time and for working with me to resolve this matter.

Sincerely,

[Your Signature]

[Your Printed Name]