Date: [Insert Date]

Patient Name: [Insert Patient Name]
Patient ID/Account Number: [Insert Account Number]
Total Balance Due: $[Insert Total Amount]

Dear [Insert Patient Name],

This letter serves as a formal agreement between **[Insert Clinic Name]** and **[Insert Patient Name]** regarding the payment of the outstanding medical balance mentioned above. Both parties agree to the following installment plan:

1. Down Payment: A down payment of $[Insert Amount] is due on [Insert Date].

2. Monthly Installments: The remaining balance shall be paid in [Number of Months] monthly installments of $[Insert Monthly Amount] each.

3. Payment Schedule: Payments are due on the [Insert Day, e.g., 1st or 15th] of each month, beginning on [Insert Start Date] and ending on [Insert End Date].

4. Method of Payment: Payments can be made via [Insert Accepted Methods, e.g., Credit Card, Check, Online Portal].

5. Terms and Conditions:

- Payments must be received by the agreed-upon due date.
- Failure to make a payment within [Number] days of the due date may result in the cancellation of this agreement.
- If the agreement is defaulted upon, the full remaining balance may become due immediately and could be referred to a collection agency.
- No interest will be charged as long as payments are made on time (or specify interest rate if applicable).

By signing below, you acknowledge that you have read, understood, and agreed to the terms of this payment plan.

Clinic Representative Signature: _____
Date: _____

Patient/Guarantor Signature: _____
Date: _____

Please return a signed copy of this letter to the billing department by [Insert Deadline Date].

Sincerely,

[Insert Name/Department]
[Insert Clinic Name]
[Insert Phone Number]