[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Re: Patient Account Number: [Account Number]

Dear [Patient Name],

This letter serves as a formal agreement between [Provider/Clinic Name] and [Patient Name] regarding the payment for medical services rendered on [Date of Service].

Total Balance Due: $[Total Amount]

By signing this agreement, you agree to pay the total balance in installments according to the following schedule:

- **Down Payment:** $[Amount] due on [Date]
- **Monthly Installment Amount:** $[Amount]
- **Number of Payments:** [Number] months
- **Payment Due Date:** The [Day, e.g., 15th] of each month
- **First Payment Date:** [Date]
- **Final Payment Date:** [Date]

Please note that all payments must be received by the due date. Failure to make timely payments may result in the full balance becoming due immediately and could lead to further collection actions.

If you have any questions or experience financial hardship that prevents you from making a payment, please contact our billing office at [Phone Number] immediately.

Please sign and return one copy of this letter to confirm your agreement.

Sincerely,

[Authorized Signature]
[Name and Title]
[Provider/Clinic Name]

Patient Acceptance:

I, [Patient Name], agree to the terms and conditions of this installment plan.

_____
[Patient Signature]

_____

[Date]