[Date]

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

Re: Payment Plan Confirmation for Account #[Account Number]

Dear [Patient Name],

This letter is to confirm that we have approved a monthly payment plan for your outstanding balance of $[Total Balance Amount] at [Healthcare Facility Name].

The terms of your agreement are as follows:

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

Please make checks payable to [Facility Name] and include your account number on the payment. You may also pay online at [Website URL] or by calling [Phone Number].

This agreement remains in effect as long as payments are received on time. If you anticipate any difficulty making a payment, please contact our billing department immediately to avoid further collection actions.

Thank you for your commitment to resolving this balance.

Sincerely,

[Sender Name]
[Billing Department/Title]
[Healthcare Facility Name]