Date: [Current Date]

Patient Name: [Patient Full Name]
Account Number: [Account Number]
Total Outstanding Balance: $[Total Amount]

Dear [Patient Name or Responsible Party],

This letter serves as a formal agreement between **[Clinic Name]** and **[Patient/Guarantor Name]** regarding the outstanding balance for medical services rendered.

Both parties agree to the following repayment schedule:

- **Initial Down Payment:** $[Amount] to be paid on [Date].
- **Monthly Installment Amount:** $[Amount]
- **Payment Frequency:** Monthly
- **Start Date:** [Date of First Installment]
- **Day of Month Due:** [Day, e.g., 15th]

Terms and Conditions:

- Payments shall be made via [Cash/Check/Credit Card/Online Portal].
- If a payment is missed, the full remaining balance may become due immediately.
- Failure to adhere to this plan may result in the account being referred to a collection agency.
- Please notify the clinic immediately if your financial circumstances change.

By signing below, you acknowledge the total debt and agree to the terms of this payment plan.

_____
Patient/Guarantor Signature

_____
Date

_____
Clinic Representative Signature

_____
Date