Date: [Insert Date]

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

Dear [Insert Patient Name],

This letter confirms the approval of a monthly installment payment plan for your outstanding medical balance at [Insert Facility Name].

The terms of your payment agreement are as follows:

- **Monthly Payment Amount:** $[Insert Amount]
- **Payment Due Date:** [Insert Day] of each month
- **Number of Installments:** [Insert Number]
- **Plan Start Date:** [Insert Date]

Payments should be sent to the following address:

[Insert Facility Name]
[Insert Billing Address]
[Insert City, State, Zip]

By following this schedule, no further collection actions will be taken. If you miss a payment or are unable to meet these terms, please contact the billing office immediately at [Insert Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Insert Name/Department]
[Insert Facility Name]