[Date]

[Parent/Guardian Name]
[Address]
[City, State, Zip Code]

Re: Patient Name: [Child's Name]
Account Number: [Account Number]

Dear [Parent/Guardian Name],

This letter confirms the installment payment plan agreement between [Clinic Name] and you regarding the outstanding balance for medical services provided to [Child's Name].

Payment Plan Details:

- Total Balance Due: $[Total Amount]
- Monthly Installment Amount: $[Amount]
- Number of Payments: [Number]
- Payment Due Date: [Day of the month, e.g., 15th]
- Start Date: [Date of first payment]

Payments can be made via [List Payment Methods: online portal, phone, or mail].

By following this schedule, your account will remain in good standing. If you anticipate any difficulty making a scheduled payment, please contact our billing department at [Phone Number] as soon as possible to discuss your options.

Thank you for choosing [Clinic Name] for your child's healthcare needs.

Sincerely,

[Signature]
[Name of Billing Representative]
[Clinic Name]