Date: [Insert Date]

Patient Name: [Insert Patient Name]
Account Number: [Insert Account Number]
Provider/Facility: [Insert Provider Name]

Specialized Care Payment Plan Agreement

This document serves as a formal agreement between **[Insert Provider/Facility Name]** and **[Insert Responsible Party Name]** regarding the payment for specialized medical services provided.

1. Payment Terms

- **Total Balance Due:** $[Insert Total Amount]
- **Down Payment Amount:** $[Insert Amount] (Paid on [Insert Date])
- **Remaining Balance:** $[Insert Amount]
- **Monthly Installment Amount:** $[Insert Amount]
- **Number of Installments:** [Insert Number]
- **Payment Due Date:** [Insert Day, e.g., 15th] of each month
- **Start Date:** [Insert Date]
- **End Date:** [Insert Date]

2. Method of Payment

Payments shall be made via [Insert Method: Credit Card/Check/Bank Transfer].

3. Late Payments and Default

If a payment is not received within [Insert Number] days of the due date, a late fee of $[Insert Amount] may be applied. Failure to adhere to this schedule may result in the account being referred to a collections agency or the suspension of non-emergency specialized care.

4. Agreement Acknowledgment

By signing below, the Responsible Party acknowledges the debt and agrees to the terms of this payment schedule.

Responsible Party Signature: _____
Date: _____

Provider Representative Signature: _____
Date: _____