Date: [Insert Date]

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

Dear [Insert Recipient Name],

This letter serves as a formal agreement between [Insert Medical Facility Name] and [Insert Responsible Party Name] regarding the payment of the outstanding medical balance listed above.

We have agreed to the following extended payment schedule:

- **Down Payment:** $[Insert Amount] due on [Insert Date]
- **Monthly Payment Amount:** $[Insert Amount]
- **Payment Due Date:** The [Insert Day, e.g., 15th] of every month
- **Number of Installments:** [Insert Number] months
- **Interest Rate:** [Insert 0% or Interest Rate]%

Payments should be made via [Insert Payment Method, e.g., online portal, check, or credit card].

By signing below, you agree to make all payments on time. Failure to adhere to this schedule may result in the full balance becoming due immediately or the account being referred to a collection agency.

If you experience financial hardship during this period, please contact our billing department at [Insert Phone Number] as soon as possible to discuss your options.

Sincerely,

[Insert Name/Signature]
[Insert Title]
[Insert Facility Name]

Agreement Acceptance:

I, [Insert Responsible Party Name], agree to the terms and conditions of this payment plan.

Signature: _____
Date: _____