

## Payment Plan of Outstanding Debt for Medical Services Rendered

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_  
Date(s) of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Your patient account has an outstanding debt for medical services rendered on the date(s) listed above. Inasmuch as the outstanding balance is sizable, we have outlined a payment plan for you as a method to retire the entire balance over the next \_\_\_\_\_ months since you have indicated that you are unable to forward the full amount at this time.

Total Amount Due: \$ \_\_\_\_\_  
Periodic Payment: \$ \_\_\_\_\_  Weekly  Monthly  
First Payment Due: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Payment Due: \_\_\_\_/\_\_\_\_/\_\_\_\_

As we do not wish to take any action which might impair your credit rating, this offer is being made to you as our expression of wanting to settle your account in an amicable manner. Failure to make any payments outlined by this arrangement will result in turning your account over to a collection agency. No additional notice of delinquency will be given.

***I hereby acknowledge and accept the payment plan for services rendered as outlined above.***

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Physician Representative**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**