

# Patient Payment Agreement

Payment plan agreement for patients with outstanding account balances

**[Practice Name]**

[Address, City, State, ZIP]  
[Phone] | [Fax]

Agreement Date: \_\_\_\_\_

Account #: \_\_\_\_\_

**PATIENT INFORMATION**

**Patient Name:** [Last, First]  
**Date of Birth:** [MM/DD/YYYY]  
**Address:** [Street, City, State, ZIP]  
**Phone:** [Phone Number]  
**Email:** [Email]  
**Guarantor (if not patient):** [Name]

**ACCOUNT BALANCE SUMMARY**

Description	Date of Service	Balance Due
[Service / Claim Description]	[MM/DD/YYYY]	\$
[Service / Claim Description]	[MM/DD/YYYY]	\$
[Service / Claim Description]	[MM/DD/YYYY]	\$
[Service / Claim Description]	[MM/DD/YYYY]	\$
<b>TOTAL OUTSTANDING BALANCE</b>		\$ _____

**PAYMENT PLAN TERMS**

The patient / guarantor agrees to pay the total outstanding balance of \$ \_\_\_\_\_ according to the following schedule:

**Down Payment (due today):** \$ \_\_\_\_\_

**Monthly Payment Amount:** \$ \_\_\_\_\_

**Payment Due Date Each Month:** [Day of month — e.g., the 1st]

**First Payment Due:** [MM/DD/YYYY]

**Final Payment Due (estimated):** [MM/DD/YYYY]

**Number of Payments:** [#] monthly installments

**Accepted Payment Methods:**  Check  Credit/Debit Card  Cash  Online Portal

**PAYMENT PLAN AGREEMENT TERMS**

By signing this agreement, the patient / guarantor agrees to the following:

