Medical Bill Payment Arrangement Agreement

Patient Name:
Account Number:
Provider Name:

Agreement Details

Total Amount Owed	
Initial Payment	
Monthly Payment Amount	
Payment Due Date (Each Month)	
Start Date	
Final Payment Date	

Terms and Conditions

- The Patient agrees to pay the Provider the total balance in accordance with this arrangement.
- Payments shall be made by the due date each month until the balance is paid in full.
- If a payment is missed or late, the Provider reserves the right to cancel this arrangement and request payment in full.
- This agreement does not waive any rights or remedies of the Provider.
- Any changes to this agreement must be made in writing and signed by both parties.

Signatures

Provider/Facility Representative Signature

_____

Date

_____

Patient/Responsible Party Signature

_____

Date

_____