

DATE: _____

PATIENT: _____

ACCOUNT BALANCE: _____

DEAR: _____

Per our conversation, we have agreed to accept monthly payments of at least \$ _____ until the account has reached a zero balance.

If at any time you will be unable to make one of these monthly payments, you agree to contact this office and keep us informed of your situation.

If this agreement is breached, the account may have to be referred to a collection agency and any additional costs of collecting the amount due will be the responsibility of the debtor.

Guarantor's Signature: _____

Date: _____

Billing Administrator: _____