

MEDICAL OFFICE PAYMENT PLAN AGREEMENT

Patient Name: _____ Account Number: _____

Agreement Parties:

Medical Office Name: _____

Medical Office Address: _____

Patient Address: _____

Patient Phone/Email: _____

Financial Terms:

Total Amount Owed: _____ USD

Down Payment Amount: _____ USD

Balance to be Paid: _____ USD

Payment Method(s): _____

Payment Schedule: _____

1. Purpose

This Payment Plan Agreement (the "Agreement") sets forth the terms under which the Medical Office agrees to accept payment for medical services rendered by the Patient in installments as detailed herein.

2. Payment Plan Terms

The Patient agrees to pay the Total Amount Owed to the Medical Office in accordance with the Payment Schedule specified above. All payments shall be made in United States Dollars (USD). Payments not received by the due date may be subject to late fees and/or collection actions.

3. Down Payment

The Patient agrees to make the Down Payment Amount upon signing this Agreement, which will be applied to the balance owed before installment payments commence.

4. Payment Schedule

Payments shall be made according to the Payment Schedule agreed upon by the parties. The Patient is responsible for making timely payments as specified. Failure to make payments on time constitutes a breach of this Agreement.

5. Payment Methods

Payments may be made via cash, check, credit/debit card, electronic funds transfer, or other mutually agreed methods. The Medical Office reserves the right to change or limit acceptable payment methods with notice.

6. Default and Remedies

If the Patient fails to make any payment when due and such failure continues for a period of ten (10) days after written notice from the Medical Office, the Medical Office may declare the entire unpaid balance immediately due and payable and pursue all available legal remedies.

7. No Waiver

The Medical Office's failure to enforce any provision of this Agreement shall not constitute a waiver of its rights or remedies.

8. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State in which the Medical Office operates, without regard to conflict of law principles.

9. Entire Agreement

This Agreement constitutes the entire agreement between the parties regarding the subject matter hereof and supersedes all prior agreements or understandings, whether written or oral.

10. Amendments

Any amendments to this Agreement must be made in writing and signed by both parties to be effective.

11. Severability

If any provision of this Agreement is found to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

12. Notices

All notices required or permitted under this Agreement shall be in writing and delivered personally, by certified mail, or by nationally recognized overnight courier to the addresses set forth herein or as updated in writing by either party.

13. Authorization

The Patient affirms that all information provided to the Medical Office is accurate and authorizes the Medical Office to apply payments according to this Agreement.

14. Collection Costs

In the event of default, the Patient agrees to pay reasonable attorneys' fees, collection costs, and court costs incurred by the Medical Office to enforce this Agreement.

15. Non-Discrimination

Nothing in this Agreement shall prevent the Medical Office from providing services or entering into payment agreements consistent with applicable federal, state, and local anti-discrimination laws.

16. Confidentiality

The Medical Office agrees to maintain the confidentiality of the Patient's medical and financial information in accordance with applicable laws and regulations.

17. Acknowledgment

By signing below, the Patient acknowledges understanding and agreement to the terms of this Payment Plan Agreement.

18. Counterparts

This Agreement may be executed in counterparts, each of which shall be deemed an original but all of which together constitute one and the same instrument.

19. Electronic Signatures

Electronic signatures shall be deemed valid and binding as originals, to the fullest extent permitted by applicable law.

20. Effective Date

This Agreement becomes effective upon the Patient's signature below and receipt of the Down Payment by the Medical Office.

PATIENT SIGNATURE

MEDICAL OFFICE REPRESENTATIVE

Signature: _____

Signature: _____

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