[Attorney Name]
[Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Medical Provider Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]

RE: Letter of Protection

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident/Injury]

To Whom It May Concern,

This office represents the above-named client regarding personal injury claims arising from an incident that occurred on [Date of Incident].

Please accept this letter as a formal Letter of Protection (LOP) regarding the medical services provided to our client. We request that you provide all necessary medical treatment to [Patient Name] and agree to withhold collection efforts against the patient personally while their legal claim is pending.

In exchange for your agreement to provide treatment and defer payment, this firm agrees to protect your outstanding medical bills. We will pay your reasonable and necessary charges directly from any settlement, judgment, or recovery obtained on behalf of the client before any funds are disbursed to the client.

Please note that this letter does not guarantee the success of the legal claim or the sufficiency of the recovery to cover all medical expenses. However, this firm will not release settlement funds to the client without first addressing your unpaid medical balance related to this matter.

If you agree to the terms of this Letter of Protection, please sign below and return a copy to our office. Please also provide us with a copy of the client's initial intake records and itemized billing statements to date.

Sincerely,

[Attorney Signature]
[Printed Name]

Acknowledgment and Acceptance:

I hereby agree to the terms of this Letter of Protection.

_____
[Medical Provider or Authorized Representative Signature]

_____
[Date]