

Date: [Date]

To: [Medical Provider Name]

[Address]

[City, State, Zip]

RE: [Patient Name]

DOB: [Patient Date of Birth]

Date of Incident: [Date of Accident/Injury]

Dear [Medical Provider or Billing Manager],

Please be advised that this office represents the above-named patient in a legal claim for personal injuries sustained on the date mentioned above.

This letter serves as a Letter of Protection regarding the medical services provided to our client. In consideration of your agreement to provide medical treatment and to defer collection of payment until the conclusion of the legal claim, we agree to protect your outstanding medical bills from any settlement or judgment proceeds received.

By accepting this letter, you agree to:

- Withhold any collection efforts against the patient during the pendency of the legal claim.
- Provide this office with copies of all medical records and itemized billing statements related to the treatment.
- Notify this office immediately if the patient's account is transferred or assigned.

Please note that this letter is a guarantee of payment from the proceeds of the legal recovery only. It does not waive the patient's ultimate responsibility for the bill should there be no recovery, nor does it guarantee the full amount of the bill if the settlement is insufficient to cover all liens.

Please sign and return a copy of this letter to acknowledge your agreement to these terms.

Sincerely,

[Attorney Signature]

[Attorney Name]

[Law Firm Name]

Acknowledge and Agreed:

By: _____ Date: _____

[Authorized Representative for Medical Provider]