

[Date]

[Attorney Name]

[Law Firm Name]

[Address]

[City, State, Zip Code]

RE: Letter of Protection

Patient Name: [Patient Name]

Date of Birth: [DOB]

Date of Injury: [Date of Incident]

Claim Number: [Claim # if applicable]

To [Attorney Name],

This document serves as a Letter of Protection regarding the orthopedic surgical care and medical treatment provided to the above-named patient for injuries sustained on [Date of Incident].

In consideration of [Surgeon Name/Practice Name] providing medical evaluation and surgical intervention, the patient and the undersigned attorney hereby agree to the following:

- The patient remains personally responsible for all medical bills incurred, regardless of the outcome of any legal action or insurance settlement.
- The attorney is instructed to withhold and pay directly to [Surgeon Name/Practice Name] any outstanding balances for medical services from any settlement, judgment, or insurance recovery.
- This Letter of Protection acts as a lien against any proceeds recovered by the patient.
- The attorney agrees to notify the medical provider immediately upon the resolution of the patient's legal claim.

Please acknowledge your agreement to these terms by signing below and returning a copy to our office.

Sincerely,

[Surgeon/Provider Signature]

ACKNOWLEDGED AND AGREED:

[Patient Signature]

Date: _____

[Attorney Signature]
Date: _____