

[Date]

[Medical Provider Name]

[Facility Name]

[Address]

[City, State, Zip]

RE: [Patient Name]

DOB: [Patient Date of Birth]

Date of Incident: [Date of Accident/Injury]

Surgical Procedure: [Type of Surgery]

Dear **[Name of Provider or Billing Department]**,

Please be advised that this office represents **[Patient Name]** in a legal claim for personal injuries sustained on the date referenced above. My client requires surgical intervention as a direct result of these injuries.

This letter serves as a Letter of Protection regarding the medical expenses incurred for the upcoming surgical procedure and related post-operative care. In consideration of your agreement to provide medical services on credit and to forego immediate collection efforts, this office agrees to protect your outstanding medical bills from any settlement, judgment, or recovery obtained on behalf of the client.

We hereby instruct you to maintain a record of all charges. Upon the resolution of this legal matter, we will withhold the necessary funds from the recovery to satisfy the outstanding balance for services rendered, provided those charges are reasonable and related to this incident.

Please note that this letter does not guarantee the recovery of any specific amount, nor does it relieve the patient of ultimate responsibility for the debt should there be no recovery. We request that you refrain from sending this account to collections or reporting it to credit agencies while this legal matter is pending.

Please sign below to acknowledge your acceptance of this agreement and return a copy to our office.

Sincerely,

[Attorney Signature]

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGMENT AND ACCEPTANCE:

I, **[Patient Name]**, hereby authorize my attorney to pay directly to the medical provider such sums as may be due and owing for medical services rendered.

[Patient Signature]

[Provider Representative Signature]

Date: _____