[Date]

[Medical Provider Name]
[Provider Address]
[City, State, Zip Code]

RE: Letter of Protection
Patient Name: [Patient Name]
Date of Incident: [Date of Incident]
Claim Number: [Claim Number, if applicable]

Dear [Medical Provider Name/Billing Department],

This office represents the above-named patient regarding injuries sustained in the incident referenced above. This letter serves as a formal Letter of Protection (LOP) concerning the medical services provided to our client.

By signing this agreement, our client authorizes and directs this office to pay directly to your facility such sums as may be due and owing for medical services rendered to the client. These payments shall be made out of any settlement, judgment, or verdict recovered on behalf of the client resulting from the aforementioned incident.

In consideration of your agreement to provide medical treatment and to wait for payment until the conclusion of the legal claim, we agree to withhold sufficient funds from any recovery to satisfy your reasonable and necessary medical charges. This agreement does not relieve the patient of their personal responsibility to pay the bill should there be no recovery, or if the recovery is insufficient to cover the total balance.

Please provide our office with copies of all medical records and itemized billing statements pertaining to the treatment of our client as they become available.

Please acknowledge your acceptance of this Letter of Protection by signing below and returning a copy to our office.

Sincerely,

[Attorney Name]
[Law Firm Name]

ACKNOWLEDGED AND AGREED:

_____
[Patient Signature]

_____

[Medical Provider Authorized Signature]