

[Date]

[Medical Provider Name]

[Clinic/Hospital Name]

[Address]

[City, State, Zip Code]

**RE: Letter of Protection Acknowledgment**

Patient Name: [Patient Full Name]

Date of Loss/Injury: [Date]

Claim Number: [Claim Number, if applicable]

Dear [Medical Provider Name or Billing Department],

This letter serves to formally acknowledge and confirm that our office represents the above-named patient in a legal claim for personal injuries sustained on the date referenced above.

Our client has requested that you provide medical services and treatment for their injuries. In consideration of your agreement to provide medical care and to defer payment until the conclusion of the legal claim, this office provides this Letter of Protection (LOP).

We hereby agree to withhold such sums from any settlement or judgment as may be necessary to satisfy your reasonable medical charges for the treatment of our client. Payment will be made directly to your office out of the proceeds of any recovery obtained on behalf of the client.

Please note the following conditions:

- This LOP applies only to treatment related to the specific injury date mentioned above.
- The client remains ultimately responsible for all medical bills incurred.
- Payment is contingent upon the successful recovery of funds through settlement or trial.

Please sign and return a copy of this letter to our office to confirm your acceptance of these terms and to ensure our records are complete.

Sincerely,

[Attorney Name]

[Law Firm Name]

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**Provider Acknowledgment:**

I hereby acknowledge receipt of this Letter of Protection and agree to the terms stated above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_