Date: [Insert Date]

To: [Medical Provider Name]
Address: [Provider Address]
City, State, Zip: [Provider City, State, Zip]

Re: Supplemental Letter of Protection
Patient Name: [Patient Name]
Date of Incident: [Date of Accident/Injury]
Claim Number: [Insurance Claim Number, if applicable]

Dear [Medical Provider Name/Billing Department],

This letter serves as a Supplemental Letter of Protection (LOP) regarding the medical treatment provided to the above-named patient in relation to the personal injury claim arising from the incident dated [Date of Incident].

This document supplements any previous agreements and confirms that our firm represents [Patient Name] in their legal claim. In consideration of your agreement to provide continued medical services on credit, we hereby agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to pay for the medical services rendered by your facility.

Payment for your services will be made directly to your office out of the proceeds of any recovery obtained on behalf of the patient. It is understood that this agreement does not relieve the patient of their personal responsibility to pay the bill in the event there is no recovery or if the recovery is insufficient to cover the total balance due.

Please provide our office with updated medical records and final billing statements once treatment is concluded to ensure accurate accounting during settlement negotiations.

Sincerely,

[Attorney Name/Law Firm Name]
[Phone Number]
[Email Address]

Acknowledgment and Consent

I, [Patient Name], hereby authorize my attorney to pay the above-mentioned medical provider directly from the proceeds of my legal claim. I understand that I remains ultimately responsible for the payment of all medical bills incurred.

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[Patient Signature]

Date: __________________