REVISED LETTER OF PROTECTION

Date: [Current Date]
To: [Imaging Center Name]
Address: [Imaging Center Address]
Fax/Email: [Imaging Center Contact Info]

RE: [Patient Name]
DOB: [Patient Date of Birth]
Date of Incident: [Date of Accident/Injury]
Our File Number: [Case Number]

To Whom It May Concern:

This letter serves as a **REVISED** Letter of Protection regarding the diagnostic imaging services provided to the above-referenced patient. This document supersedes any previously issued Letter of Protection for the dates of service listed below.

I represent the patient in a legal claim for personal injuries sustained on the date of incident mentioned above. In consideration of your agreement to provide medical services on credit, my client and this firm agree to the following:

1. **Payment from Settlement:** We will withhold from any recovery (settlement or judgment) sufficient funds to pay your outstanding balance for the imaging services rendered.
2. **Direct Payment:** Payment will be made directly to your facility at the time of the final settlement or distribution of funds.
3. **Attorney Lien:** This letter creates a lien against any proceeds recovered in this case in favor of your facility.
4. **Updates:** We request that you provide our office with the final itemized billing statement and the formal imaging reports immediately following the procedure.

Please note that this letter does not guarantee the success of the legal claim, nor does it relieve the patient of the ultimate responsibility for the bill should there be no recovery. However, this firm agrees to notify your office immediately upon the conclusion of the legal matter.

Please update your records to reflect this revised agreement. If you require further information, please contact our office.

Sincerely,

[Attorney Signature]
[Attorney Name]
[Law Firm Name]

Patient Acknowledgment:

I hereby authorize my attorney to pay the aforementioned imaging facility directly from the proceeds of my legal recovery and acknowledge my ultimate financial responsibility for these services.

[Patient Signature]: _____
Date: _____