LETTER OF PROTECTION

DATE: [Insert Date]

TO: [Name of Imaging Facility]
ADDRESS: [Facility Address]
FAX/EMAIL: [Facility Contact Info]

RE: [Patient Name]
DOB: [Patient Date of Birth]
DOT: [Date of Traffic Accident/Injury]
CLAIM NUMBER: [Insurance Claim Number]

To Whom It May Concern,

This office represents the above-named patient regarding injuries sustained in an accident on the date referenced above. My client requires radiographic diagnostic imaging services (MRI, CT, X-Ray) related to these injuries.

Please accept this Letter of Protection as a guarantee that our office will protect your outstanding medical bills for services rendered to this patient. We agree to pay your reasonable charges directly from any settlement, judgment, or verdict received on behalf of the patient before any funds are distributed to the client.

In the event that there is no recovery or the recovery is insufficient to cover the medical expenses, the patient remains personally responsible for the payment of your bill.

Please provide this office with a copy of the diagnostic reports and the final billing statement as soon as they are available.

Thank you for your cooperation in providing medical care to my client.

Sincerely,

[Attorney Name/Signature]
[Law Firm Name]
[Phone Number]

PATIENT ACKNOWLEDGMENT

I hereby authorize my attorney to pay the aforementioned medical provider directly from the proceeds of any settlement or judgment. I understand that I am ultimately responsible for this debt regardless of the outcome of my legal case.

Patient Signature: _____
Date: _____