LETTER OF PROTECTION

Date: [Date]

To: [Name of Surgical Center/Facility]
[Address]
[City, State, Zip]

Re: [Patient Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident/Injury]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

This office represents the above-named patient in a legal claim for personal injuries sustained on the date referenced above. My client requires outpatient surgical intervention for injuries resulting from this incident.

Please accept this Letter of Protection regarding the medical services and surgical procedures provided to [Patient Name]. By this letter, we agree to protect your outstanding medical bills for the outpatient surgery from any settlement, judgment, or verdict received by the patient in connection with this claim.

We instruct you to maintain a record of all charges incurred. This office will withhold and pay directly to your facility the necessary sums for medical services rendered from any recovery obtained, prior to the distribution of any proceeds to the client.

Please note that this letter does not guarantee payment if there is no recovery. In the event no recovery is made, the patient remains personally responsible for the payment of all medical bills incurred.

Please sign below to acknowledge your acceptance of this Letter of Protection and return a copy to our office.

Sincerely,

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

ACKNOWLEDGMENT AND ACCEPTANCE:

The undersigned facility hereby accepts the terms of this Letter of Protection.

By: ______________________________
Title: _____________________________
Date: _____________________________