

Date: [Date]

TO: [Hospital Name/Surgical Center Name]
ATTN: Billing Department / Financial Services
ADDRESS: [Facility Address]

RE: LETTER OF PROTECTION

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Injury: [Date of Incident]
Proposed Procedure: [Name of Surgery/Inpatient Procedure]

To Whom It May Concern,

Please be advised that this office represents the above-named patient in a legal claim for personal injuries sustained on the date referenced above. It is our understanding that the patient requires inpatient surgical intervention as a direct result of these injuries.

In consideration of your agreement to provide the necessary surgical facilities, inpatient care, and related medical services on a credit basis, this letter shall serve as a formal Letter of Protection. We hereby agree to withhold and pay directly to your facility such sums as may be due and owing for medical services rendered to our client from any settlement, judgment, or verdict received in this matter.

The patient further authorizes and directs the undersigned attorney to pay your facility directly from the proceeds of any recovery. This letter does not guarantee the success of the claim, nor does it relieve the patient of the ultimate personal responsibility for the medical debt; however, it ensures that your facility will be protected upon the distribution of any legal recovery.

Please provide this office with a copy of the itemized billing statement and the operative report once the procedure is completed.

Sincerely,

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

Acknowledge and Agreed:

[Patient Signature]