

Date: [Date]

To: [Surgeon Name/Medical Facility]

Address: [Street Address]

City, State, Zip: [City, State, Zip]

RE: [Patient Name]

DOB: [Patient Date of Birth]

Date of Incident: [Date of Accident/Injury]

Claim Number: [Insurance Claim Number]

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. This letter serves as a Letter of Protection regarding the reconstructive surgical intervention and related medical services provided to our client.

In consideration of your agreement to provide medical treatment and surgical services on a credit basis, we hereby agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to satisfy your itemized medical billings. Payment will be made directly to your office out of the proceeds of any recovery obtained on behalf of the patient.

Please note that this letter does not guarantee payment from our firm's own funds, but rather acts as a lien against any recovery received. The patient remains ultimately responsible for the payment of all medical expenses incurred.

We request that you provide this office with copies of all medical records and itemized billing statements pertaining to the reconstructive surgery once the procedure is completed.

Acknowledged and Agreed:

Attorney Signature

Patient Signature