

LETTER OF PROTECTION

DATE: [Date]

TO: [Name of Medical Provider/Facility]

ADDRESS: [Address of Provider]

RE: [Patient Name]

DATE OF INCIDENT: [Date of Accident/Injury]

CLAIM NUMBER: [Insurance Claim Number, if applicable]

To Whom It May Concern,

This office represents the above-named patient in a legal claim for personal injuries sustained in the incident referenced above. Our client requires pain management surgical intervention, specifically: [Description of Procedure].

This letter shall serve as a Letter of Protection regarding the medical expenses incurred for this procedure and related care. In consideration for your agreement to provide medical services on credit and to refrain from seeking immediate payment from the patient, we agree to the following:

1. We will withhold and pay directly to your office, from any settlement, judgment, or recovery obtained on behalf of the patient, the total amount of your reasonable and necessary medical charges.
2. The patient has signed this document below, granting a lien to your facility against any proceeds from their legal claim.
3. This letter does not guarantee that a recovery will be made, but it does guarantee that your bill will be paid out of any such recovery before any funds are distributed to the patient.

Please provide us with a copy of the final itemized billing statement and the operative report once the procedure is complete.

Sincerely,

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGMENT AND ASSIGNMENT BY PATIENT

I hereby authorize my attorney to pay directly to the medical provider named above any sums due for services rendered to me. I hereby grant said provider a lien on any settlement or judgment proceeds from my legal claim. I understand that I remain personally responsible for these medical bills regardless of the outcome of my legal case.

[Patient Signature]

[Date]