

Date: [Date]

To: [Name of Surgeon/Medical Facility]

Address: [Surgeon's Address]

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

RE: [Patient Name]

Date of Incident: [Date of Accident/Injury]

Procedure: Maxillofacial Surgical Intervention

Dear [Surgeon Name or Billing Department],

This letter serves as a formal Letter of Protection regarding the medical treatment and maxillofacial surgical services provided to my client, [Patient Name], for injuries sustained in the incident referenced above.

I represent [Patient Name] in a legal claim for damages. We understand that my client requires surgical intervention to treat [Briefly describe injury, e.g., facial fractures or jaw misalignment].

Please be advised that this office will protect your interest regarding the medical bills incurred for this surgery. We agree to withhold and pay the necessary funds to satisfy your surgical and facility fees directly from any settlement or judgment received in this matter, prior to any distribution to the client.

In the event that the claim is resolved without a recovery, or if the recovery is insufficient to cover the full amount of the medical expenses, the responsibility for payment remains with the patient.

Please provide my office with a copy of the surgical reports and the final itemized billing statement once the procedure is complete. If you agree to provide services under these terms, please sign below and return a copy to my office.

Sincerely,

[Attorney Signature]

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGED AND AGREED:

[Surgeon/Facility Representative Signature]

[Date]

[Patient/Client Signature]