Date: [Date]

To: [Name of Surgical Center/Facility]
Address: [Facility Address]
Attention: Billing/Financial Department

RE: Letter of Protection

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident]
Type of Procedure: [Name of Surgical Intervention]

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 mentioned above. This letter serves as a Letter of Protection regarding the ambulatory surgical services provided to our client.

In consideration of your agreement to provide medical services and surgical intervention to the patient without immediate payment, we hereby agree to protect your medical bills out of any settlement, judgment, or verdict received in this matter. We are authorized by the client to withhold sufficient funds from any recovery to satisfy your outstanding balance related to this specific procedure.

Payment will be made directly to your facility at the time of the final settlement or resolution of the case. Please note that this letter does not guarantee a specific recovery amount, but it ensures that your facility will be paid prior to the distribution of net proceeds to the client.

Please provide us with copies of all medical records and itemized billing statements following the procedure. If you agree to these terms, please sign below and return a copy to our office.

Sincerely,

[Attorney Name]
[Law Firm Name]

ACKNOWLEDGMENT AND AGREEMENT:

I, [Patient Name], hereby authorize my attorney to pay the medical provider directly from the proceeds of my legal claim. I understand that I remains personally responsible for this debt should there be no recovery or if the recovery is insufficient to cover the balance.

____
Patient Signature

____
Facility Representative Signature