Date: [Date]

To: [Attorney Name/Law Firm]
Address: [Attorney Address]
City, State, Zip: [City, State, Zip]

Re: Irrevocable Letter of Protection
Patient: [Patient Name]
Date of Incident: [Date of Incident]
Claim Number: [Claim Number (if applicable)]

Dear [Attorney Name],

This document serves as an Irrevocable Letter of Protection regarding the physical therapy services provided by [Physical Therapy Clinic Name] ("Provider") to the above-named Patient for injuries sustained in the incident dated [Date of Incident].

In consideration of the Provider's agreement to perform physical therapy services and to defer immediate payment for said services, the Patient and the undersigned Attorney hereby agree to the following:

1. The Patient hereby grants the Provider a lien on any and all proceeds of any settlement, judgment, or verdict which may be paid to the Patient or the Attorney as a result of the injuries for which the Patient has been treated.
2. The Attorney is hereby authorized and directed to withhold such sums from any settlement, judgment, or verdict as are necessary to pay the Provider's outstanding balance in full.
3. The Attorney agrees to pay the Provider directly out of the proceeds of any recovery immediately upon receipt of such funds, prior to any distribution to the Patient.
4. This Letter of Protection is irrevocable and shall remain in full force and effect regardless of any change in legal representation or any dispute regarding the underlying legal claim.
5. The Patient remains ultimately responsible for the total amount of the bill, and this agreement does not relieve the Patient of the personal obligation to pay for services rendered if no recovery is obtained.

Please acknowledge your agreement to the terms of this Irrevocable Letter of Protection by signing below and returning a copy to our office.

Sincerely,

_____
[Authorized Representative Name]
[Physical Therapy Clinic Name]

ACKNOWLEDGMENT AND AGREEMENT:

I have read and understand the terms above and agree to be bound by them.

_____ Date: _____
[Patient Name]

I, the undersigned attorney, agree to honor this Irrevocable Letter of Protection and to withhold and pay the Provider's fees from any recovery obtained.

_____ Date: _____
[Attorney Name]