[Date]

[Physical Therapy Clinic Name]
[Clinic Address]
[City, State, Zip Code]

RE: Letter of Protection
Patient Name: [Patient Full Name]
Date of Accident: [Date of Incident]
Claim Number: [Insurance Claim Number, if known]

To Whom It May Concern,

This office represents **[Patient Name]** in legal claims arising from the personal injuries sustained in the accident referenced above. Please accept this Letter of Protection regarding the physical therapy services provided to our client.

We hereby authorize and direct you to provide all necessary physical therapy treatment to our client. In consideration for your agreement to provide medical services on credit, we agree to protect your outstanding balance and will pay your fees directly from any settlement, judgment, or recovery obtained on behalf of the client.

Please note that this letter does not guarantee the recovery of any specific amount of money, but it serves as a formal lien against any proceeds received. Payment will be issued to your facility upon the final resolution and distribution of the case funds.

We request that you provide this office with copies of all medical records and itemized billing statements as the treatment progresses. Our client remains ultimately responsible for the payment of your bills should there be no recovery in this matter.

Please acknowledge your acceptance of these terms by signing below and returning a copy to our office.

Sincerely,

[Attorney Name/Law Firm Name]
[Attorney Signature]

ACCEPTED AND AGREED:

By: _____
(Authorized Representative for Physical Therapy Clinic)

Date: _____

CLIENT ACKNOWLEDGMENT:

By: _____
(Patient/Client Signature)

Date: _____