

LETTER OF PROTECTION

Date: [Date]

To: [Name of Medical Provider/Clinic]

Address: [Provider Address]

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

RE: [Patient Name]

Date of Birth: [DOB]

Date of Incident: [Date of Accident/Injury]

Patient Account Number: [Account Number if applicable]

To Whom It May Concern,

This office represents the above-named client regarding injuries sustained in the incident referenced above. Our client requires post-surgical pain management services and/or follow-up care as a direct result of these injuries.

This letter shall serve as a Letter of Protection concerning the medical bills incurred for the treatment provided to our client. In consideration of your agreement to provide medical services on credit, we agree to withhold and pay to your facility such sums as may be due and owing for medical services rendered to our client from any settlement, judgment, or verdict received in this matter.

Please note that this agreement does not guarantee payment from the client's legal counsel personally, but rather acts as a lien against any recovery obtained. In the event there is no recovery, the patient remains personally responsible for the payment of all medical charges.

We request that you provide us with copies of all medical records and itemized billing statements upon completion of treatment.

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

Sincerely,

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGED AND AGREED:

Medical Provider Authorized Signature

Date

Patient/Client Signature