REVISED LETTER OF PROTECTION

DATE: [Current Date]

TO: [Medical Provider Name/Facility Name]
ATTN: Billing/Medical Records Department
ADDRESS: [Provider Address]

RE: [Patient/Client Name]
DOB: [Patient Date of Birth]
DOI: [Date of Incident/Injury]
CLAIM NUMBER: [Insurance Claim Number]

Dear [Medical Provider Name],

This letter serves as a **REVISED** Letter of Protection regarding the pain management treatment for the above-referenced client. This letter supersedes any prior Letter of Protection issued on [Date of Original Letter].

The scope of this agreement has been revised to include the following additional procedures and/or services:

- [Description of specific procedure, e.g., Cervical Epidural Steroid Injection]
- [Description of specific procedure, e.g., Radiofrequency Ablation]
- [Additional diagnostic testing or follow-up consultations]

In consideration for your agreement to provide these revised services on credit, this office agrees to protect your outstanding medical bills for the aforementioned patient. We will withhold and pay the necessary funds to satisfy your bill directly from any settlement, judgment, or recovery obtained on behalf of the client resulting from the incident on [Date of Incident].

Please note the following conditions:

1. Payment is contingent upon the successful recovery of funds.
2. The client remains ultimately responsible for the payment of all medical services rendered should there be no recovery.
3. Please provide our office with updated itemized billing statements and procedure reports following each visit.

By signing below, the client acknowledges and authorizes this revised agreement and directs the undersigned attorney to make payment as described.

Sincerely,

[Attorney Name]
[Law Firm Name]

ACKNOWLEDGMENT AND AGREEMENT:

_____
[Client Signature]
Date: [Date]

_____
[Attorney Signature]
Date: [Date]