LETTER OF PROTECTION

DATE: [Date]

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

RE: [Patient Name]
DOB: [Patient Date of Birth]
DOT: [Date of Incident/Accident]
CLAIM #: [Insurance Claim Number, if applicable]

To Whom It May Concern,

Please be advised that this office represents the above-named patient regarding personal injury claims arising from the accident occurring on the date referenced above.

This letter serves as a Letter of Protection concerning the diagnostic imaging (MRI, CT, X-Ray) and pain management services provided to our client. My client is currently unable to pay for these medical services at this time. In consideration of your agreement to provide medical treatment and/or diagnostic services on credit, we hereby agree to the following:

1. **Payment from Settlement:** We agree to withhold and pay directly to your facility such sums as may be due and owing for medical services rendered to our client out of any settlement, judgment, or verdict received.

2. **Lien:** Our client hereby grants a lien on their claim to your facility to the extent of the reasonable value of the services provided.

3. **Direct Payment:** Our client hereby authorizes and directs us, as their attorneys, to pay your facility directly from the proceeds of any recovery.

4. **Final Responsibility:** Our client understands that they remain ultimately responsible for the payment of all medical bills regardless of the outcome of the legal case.

Please provide us with a copy of all medical reports and itemized billing statements immediately following the completion of services.

Sincerely,

[Attorney Name]
[Law Firm Name]
[Phone Number]

ACKNOWLEDGED AND AGREED:

____
[Patient Signature]

____
[Date]