

Date: [Insert Date]

To: [Name of Trauma Center/Medical Facility]

Attn: Billing/Medical Records Department

Address: [Insert Address]

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

RE: Letter of Protection

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Date of Incident: [Insert Date of Accident/Injury]

Account Number: [Insert Account Number, if known]

To Whom It May Concern:

Please be advised that this firm represents the above-named patient in a legal claim for personal injuries sustained in the incident referenced above.

This letter shall serve as a Letter of Protection regarding the medical services and treatment provided by your facility to our client. In consideration for your agreement to provide medical care and/or to withhold immediate collection efforts, we hereby agree to protect your outstanding medical bills from any settlement, judgment, or verdict received by the patient in connection with this claim.

We further agree to notify your office upon the resolution of this matter and to disburse the reasonable and necessary costs of your services directly from the proceeds of the recovery before any funds are distributed to the client. This agreement is irrevocable and shall be binding upon this firm and any successor counsel.

Please note that this Letter of Protection is not a guarantee of payment if no recovery is made. The patient remains ultimately responsible for the payment of all medical expenses incurred.

Please provide us with a current statement of charges and all medical records associated with this treatment. If you accept the terms of this Letter of Protection, please sign below and return a copy to our office.

Sincerely,

[Attorney Signature]

[Attorney Name]

[Law Firm Name]

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**ACKNOWLEDGMENT AND AGREEMENT:**

I, the patient, hereby authorize and direct my attorney to pay the medical provider directly from the proceeds of any settlement or judgment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Accepted by (Medical Provider): \_\_\_\_\_ Date: \_\_\_\_\_