LETTER OF PROTECTION

Date: [Date]

To: [Name of Urgent Care Facility]
Address: [Facility Address]
City, State, Zip: [City, State, Zip]

RE: Patient Name: [Patient Full Name]
Date of Incident: [Date of Accident/Injury]
Claim Number: [Insurance Claim Number, if applicable]

To Whom It May Concern,

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

This letter serves as a Letter of Protection regarding the medical services and treatment provided by your facility to our client. We hereby request that you provide all necessary medical care to our client and withhold any collection efforts against the patient personally pending the resolution of their legal claim.

In consideration for your services, we agree to protect your outstanding balance and will pay the reasonable costs of the medical services rendered directly from any settlement, judgment, or recovery obtained on behalf of the client. Payment will be made directly to your facility at the time of the distribution of funds.

Please provide us with a copy of all medical records and itemized billing statements for the treatment provided. We also request that you notify our office immediately if there is a change in the status of the client's treatment or if the balance exceeds a specific threshold.

By signing below, the patient also authorizes and directs their attorney to pay the medical provider directly from the proceeds of any recovery.

Sincerely,

[Attorney Name]
[Law Firm Name]

PATIENT ACKNOWLEDGMENT AND AUTHORIZATION

I hereby authorize my attorney to pay [Name of Urgent Care Facility] directly from any settlement or judgment received. I understand that I remain ultimately responsible for the payment of my medical bills regardless of the outcome of my legal case.

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[Patient Signature]

Date: ________________