

**Date:** [Insert Date]

**To:** [Medical Facility/Surgeon Name]

**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]

**Claim Number:** [Insert Claim Number, if applicable]

To Whom It May Concern,

This office represents the above-named patient in a legal claim for personal injuries sustained in the incident referenced above. Our client requires emergency surgical intervention for injuries resulting from this incident.

In consideration for your agreement to provide medical services and surgical intervention on credit, this letter serves as a formal Letter of Protection. We hereby agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to pay for the medical services rendered to our client by your facility.

Payment shall be made directly to your office out of the proceeds of any recovery obtained on behalf of the client. This agreement is a lien against any such recovery and shall not be superseded by any subsequent instructions from the client, as the client has signed below acknowledging this obligation.

Please note that this letter does not guarantee payment from the attorney's personal funds; it is a guarantee of payment from the proceeds of the case. In the event there is no recovery, the patient remains personally responsible for the medical expenses incurred.

Please provide us with a final itemized statement and all relevant medical records immediately following the procedure.

Sincerely,

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[Attorney Signature]

[Attorney Name]

[Law Firm Name]

**ACKNOWLEDGMENT BY PATIENT**

I hereby authorize my attorney to pay the medical provider directly from any settlement or judgment for all medical bills related to this surgery. I understand that I am ultimately responsible for these bills regardless of the outcome of my legal case.

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[Patient Signature]

[Date]