DENTAL PROVIDER LETTER OF PROTECTION ACKNOWLEDGMENT AND ACCEPTANCE

Date: [Date]

To: [Attorney Name/Law Firm]
Address: [Attorney Street Address]
City, State, Zip: [City, State, Zip]

RE: [Patient Name]
Date of Incident: [Date of Accident/Injury]
Your File Number: [File Number]

Dear [Attorney Name],

I, [Provider Name/Practice Name], hereby acknowledge receipt of the Letter of Protection (LOP) dated [Date of LOP] regarding the above-referenced patient.

By signing this document, I/we agree to the following terms:

- I/we will withhold seeking payment from the patient for dental services related to the injury mentioned above until the conclusion of the patient's legal claim.
- I/we acknowledge that the patient has granted a lien in favor of this dental practice against any settlement, judgment, or insurance proceeds recovered in this matter.
- I/we understand that payment of our final billing is to be made directly by your office from the proceeds of any recovery prior to distribution to the patient.
- I/we will provide the necessary dental records and final billing statements to your office upon request to facilitate the settlement of this claim.

This acceptance is contingent upon the understanding that the attorney will notify this office immediately upon the resolution of the case and will protect our outstanding balance from any funds received.

Please keep this signed acknowledgment in your files as confirmation of our agreement.

Sincerely,

_____
Authorized Signature

[Printed Name and Title]
[Dental Practice Name]
[Phone Number]
[Tax ID Number]