[Surgical Center Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

RE: Letter of Protection Acknowledgment and Acceptance

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident/Injury]
Attorney/Law Firm: [Attorney Name/Firm Name]

To [Attorney Name],

This letter serves as formal acknowledgment and acceptance of the Letter of Protection (LOP) received by [Surgical Center Name] on [Date LOP Received] regarding the medical services provided to the above-referenced patient.

[Surgical Center Name] agrees to provide the necessary surgical services and medical care to the patient on a credit basis. In exchange, it is understood and agreed that:

- The patient and their legal counsel shall protect the outstanding balance owed to [Surgical Center Name] from any settlement, judgment, or insurance recovery.
- Payment shall be made directly to [Surgical Center Name] immediately upon the resolution of the legal claim.
- The patient remains ultimately responsible for the total cost of services rendered, regardless of the outcome of the legal case or the amount of any settlement.
- The Attorney agrees to notify [Surgical Center Name] immediately upon the settlement or conclusion of the case.

Our current estimated charges for the scheduled procedure are: $[Amount]. Please note this is an estimate and final charges will be based on the actual services provided.

Please sign below to confirm your agreement to these terms and return a copy to our billing department.

Sincerely,

[Signature]
[Name of Authorized Representative]
[Title]
[Surgical Center Name]

Attorney Acceptance:

I hereby acknowledge the terms stated above and agree to protect the medical lien/bill of [Surgical Center Name] from any recovery received on behalf of [Patient Name].

_____
[Attorney Signature]

_____
[Date]