

Date: [Date]

To: [Medical Provider Name/Facility]

Address: [Provider Address]

RE: Conditional Letter of Protection and Fee Cap Agreement

Patient: [Patient Name]

Date of Incident: [Date of Incident]

Law Firm File Number: [File Number]

Dear [Medical Provider Name],

This office represents [Patient Name] regarding injuries sustained in the above-referenced incident. Our client wishes to receive medical treatment from your facility on a lien basis.

1. Letter of Protection: Our client hereby authorizes and directs this firm to pay directly to your office sums as may be due and owing for medical services rendered to the client. These payments shall be made out of any settlement, judgment, or verdict received by the client as a result of the legal claims arising from the incident noted above.

2. Conditional Nature: This agreement is strictly conditional upon the successful recovery of funds. If no recovery is made, or if the recovery is insufficient to cover all legal costs and superior liens, the client remains personally responsible for the medical debt.

3. Fee Cap Agreement: By accepting this Letter of Protection, you agree to a "Fee Cap." You agree that your total recovery for services rendered under this lien shall not exceed [Percent, e.g., 33%] of the net recovery available for medical providers, or [Dollar Amount Cap], whichever is lower. Furthermore, you agree to negotiate in good faith should the total medical liens exceed the available settlement funds.

4. Billing: Please provide this office with copies of all medical records and itemized billing statements immediately upon the conclusion of treatment.

5. Acceptance: Please indicate your acceptance of these terms by signing below and returning a copy to our office. No services should be rendered under this lien until a signed copy is received.

Sincerely,

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGED AND AGREED:

Medical Provider Authorized Signature

Printed Name and Title

Date