

**Date:** [Insert Date]

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

**Address:** [Provider Address]

**City, State, Zip:** [City, State, Zip]

**RE: Conditional Letter of Protection**

**Patient Name:** [Patient Name]

**Date of Birth:** [Date of Birth]

**Date of Incident:** [Date of Accident/Injury]

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

Dear [Medical Provider Name],

This letter serves as a Conditional Letter of Protection (CLOP) regarding the surgical services and medical care provided to the above-referenced patient for injuries sustained on [Date of Incident].

Our law firm represents [Patient Name] in a legal claim for damages. In consideration of your agreement to provide necessary surgical intervention and related medical treatment on credit, we hereby agree to protect your medical lien against any settlement or judgment obtained in this specific matter, subject to the following conditions:

1. **Source of Payment:** Payment for your services will be made directly from the net proceeds of any recovery (settlement or verdict) received by the patient.
2. **Contingency:** This letter is not a guarantee of payment. Payment is strictly contingent upon the successful recovery of funds. If there is no recovery, the patient remains personally responsible for the medical expenses.
3. **Billing:** You agree to provide our office with final itemized billing statements and relevant medical records immediately following the procedure.
4. **Disbursement:** Upon receipt of settlement funds, we will withhold the amount owed for your services (or a negotiated amount) and will not distribute those funds to the client until your outstanding balance is addressed.

Please acknowledge your acceptance of this Conditional Letter of Protection by signing below and returning a copy to our office.

Sincerely,

[Attorney Name]

[Law Firm Name]

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**Acknowledgment and Acceptance:**

I, [Medical Provider Name], hereby agree to the terms of this Conditional Letter of Protection.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Consent:**

I, [Patient Name], hereby authorize my attorney to pay the medical provider directly from the proceeds of my legal claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_