

**Date:** [Date]

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

**Address:** [Provider Address]

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

**Re:** Letter of Protection

**Patient Name:** [Client Name]

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

**Your Reference/Account #:** [Account Number if applicable]

Dear [Medical Provider or Billing Manager],

Please be advised that this office represents [Client Name] in a legal claim for personal injuries sustained on the date referenced above.

This letter serves as a **Conditional Letter of Protection**. Our firm agrees to protect your outstanding medical bills related to this incident and will endeavor to pay them directly from any settlement or judgment proceeds received on behalf of our client, subject to the following conditions:

- **Treatment Compliance:** The client must strictly adhere to the treatment plan prescribed by your facility, attending all scheduled appointments and following medical advice.
- **Full Documentation:** Your office must provide all medical records and itemized billing statements promptly upon request.
- **Notification of Discharge:** Your office must notify us once the client has reached Maximum Medical Improvement (MMI) or has completed treatment.

This agreement is not a guarantee of payment if no recovery is obtained. Furthermore, this letter does not waive our client's right to dispute the reasonableness or necessity of any specific charges or to negotiate the final balance at the time of settlement.

Please sign below to acknowledge your acceptance of these terms and return a copy to our office. Upon receipt of the signed agreement, we will instruct our client to proceed with treatment at your facility.

Sincerely,

[Attorney Name]

[Law Firm Name]

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**Acknowledge and Agreed by Medical Provider:**

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

Printed Name/Title: \_\_\_\_\_