

Date: [Date]

To: [Pain Management Provider Name]

Address: [Provider Address]

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

Re: Patient Financial Responsibility / Letter of Protection

Patient Name: [Patient Full Name]

Date of Loss/Injury: [Date]

Claim Number: [Claim Number, if available]

Dear [Provider Name or Billing Department],

This letter serves as a Conditional Letter of Protection regarding the medical treatment and pain management care provided to the above-referenced patient for injuries sustained on [Date of Loss].

Our firm represents [Patient Name] in a legal claim for damages arising from this incident. We understand that the patient is currently seeking treatment at your facility and may be unable to pay for services at the time they are rendered.

Terms of Protection:

In consideration for your agreement to provide medical services on credit, our firm agrees to protect your outstanding medical bills out of any settlement, judgment, or recovery received on behalf of the patient, subject to the following conditions:

- A recovery is actually obtained through settlement or final judgment.
- The patient remains a client of this firm at the time of recovery.
- The total recovery is sufficient to satisfy all superior liens and legal costs.

Provider Obligations:

By accepting this Letter of Protection, the provider agrees to:

- Withhold any collection efforts or reporting to credit bureaus against the patient pending the outcome of the legal claim.
- Provide this firm with copies of all medical records and itemized billing statements upon request.
- Notify this firm immediately of any changes in the patient's treatment status.

Please note that this letter does not constitute a personal guarantee of payment by this law firm. The ultimate responsibility for payment of your charges remains with the patient.

Please acknowledge your acceptance of these terms by signing below and returning a copy to our office.

Sincerely,

[Attorney Name]
[Law Firm Name]

Acknowledge and Agreed:

Authorized Signature for [Provider Name]

Date: _____