

**Date:** [Insert Date]

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

**ADDRESS:** [Provider Address]

**RE:** [Patient Name]

**DATE OF INCIDENT:** [Date of Accident/Injury]

**CLAIM NUMBER:** [Insert Claim Number, if applicable]

**SUBJECT: DECLARATION OF THE LIMITED LIABILITY LETTER OF PROTECTION**

To Whom It May Concern,

This letter serves as a formal Declaration of a Limited Liability Letter of Protection regarding the medical services provided to my client, [Patient Name], for injuries sustained in the above-referenced incident.

Please be advised that [Law Firm Name] represents the patient in a legal claim for damages. We hereby request that you provide necessary medical treatment to the patient on a credit basis. In consideration for such services, the patient and this firm agree to the following terms:

- 1. Lien on Recovery:** The patient hereby grants a lien to [Medical Provider Name] against any settlement, judgment, or recovery obtained as a result of the legal claim related to the incident specified above.
- 2. Payment from Proceeds:** [Law Firm Name] agrees to withhold sufficient funds from any net recovery received on behalf of the patient to satisfy the outstanding balance for medical services rendered, subject to final verification of the bill.
- 3. Limited Liability:** This letter does not constitute a guarantee of payment by the law firm from its own funds. Payment is strictly contingent upon the successful recovery of funds through settlement or trial. If no recovery is made, the patient remains personally responsible for the balance of the medical bills.
- 4. Direct Payment:** Upon resolution of the case, payment will be issued directly to your office from the firm's trust account once the funds are cleared.

Please sign below to acknowledge receipt and acceptance of this Letter of Protection and return a copy to our office. Please also provide copies of all future medical records and billing statements related to this patient's care.

Sincerely,

[Attorney Name]

[Law Firm Name]

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**ACKNOWLEDGMENT AND AGREEMENT:**

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

\_\_\_\_\_  
Patient Signature

Accepted by [Medical Provider Name]:

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Authorized Representative Signature