[Date]

[Medical Provider Name]
[Address]
[City, State, Zip Code]

RE: Letter of Protection (Maximum Balance Agreement)

Patient Name: [Patient Name]
Date of Incident: [Date of Incident]
Claim Number: [Claim Number]

Dear Billing Department,

Our office represents the above-named client regarding injuries sustained in the aforementioned incident. This letter serves as a Letter of Protection (LOP) to secure payment for medical services rendered to our client.

By accepting this letter, you agree to provide medical treatment and withhold direct collection efforts against the client pending the resolution of their legal claim. In exchange, this office agrees to protect your outstanding balance and issue payment directly from any settlement or judgment proceeds received.

Maximum Balance Cap:
Please be advised that this Letter of Protection is strictly limited to a maximum total balance of **$[Amount]**. Any charges incurred beyond this specified amount will not be covered under the terms of this agreement unless a written extension is authorized by this office in advance.

Upon final resolution of the case, we will contact your office to verify the final itemized statement. Payment will be disbursed directly to your office from our client trust account at the time of settlement distribution.

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

Sincerely,

[Attorney Name]
[Law Firm Name]

Agreed and Accepted By:

Signature: _____ Date: _____

Printed Name/Title: _____