

**Date:** [Date]

**To:** [Medical Provider Name]

**Address:** [Provider Address]

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

**RE: Letter of Protection (Capped)**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Date of Incident:** [Date of Incident]

**Our File Number:** [File Number]

Dear [Medical Provider/Billing Manager],

This office represents the above-named client in a legal claim for personal injuries sustained in the incident referenced above.

This letter serves as a Letter of Protection regarding the medical services provided to our client. By accepting this letter, you agree to look to the proceeds of any future settlement or judgment for payment of your services, rather than seeking immediate payment from the client.

**Capped Amount:** Please be advised that this Letter of Protection is capped at a maximum total amount of **\$(Insert Dollar Amount)**. Any charges incurred beyond this specific amount are not covered by this agreement and must be authorized separately in writing by this office.

Upon the resolution of this claim, this office will withhold the necessary funds from the settlement proceeds to satisfy your bill, up to the maximum cap stated above, less any applicable reductions or prior payments. We request that you cease all collection efforts against the client while this claim is pending.

Please provide us with copies of all medical records and itemized billing statements as treatment progresses.

Sincerely,

[Attorney Signature]

[Attorney Name]

[Law Firm Name]

**Acknowledge and Agreed:**

\_\_\_\_\_  
[Medical Provider Representative Name/Title]

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