

DATE: [Date]

TO: [Medical Provider Name]

[Address]

[City, State, Zip Code]

RE: Letter of Protection (Restricted Amount)

PATIENT: [Patient Name]

DATE OF INCIDENT: [Date of Accident/Injury]

CLAIM NUMBER: [Claim Number, if applicable]

Dear [Medical Provider Name],

This office represents [Patient Name] regarding legal claims arising from the above-referenced incident. This letter serves as a formal Letter of Protection concerning the medical services provided to our client.

Please be advised that we will protect your outstanding balance for services related to this specific incident out of any settlement, judgment, or recovery obtained on behalf of the client. However, please note the following restriction:

This Letter of Protection is strictly limited to a maximum total amount of \$[Dollar Amount].

Any charges incurred beyond this restricted amount are not covered by this agreement. We request that you provide us with a complete set of medical records and a final itemized billing statement upon the conclusion of treatment.

By accepting this Letter of Protection, you agree to look solely to the proceeds of the legal claim for payment up to the restricted amount and to withhold any independent collection efforts against the client while the legal matter is pending.

Please sign below and return a copy to our office to acknowledge your acceptance of these terms.

Sincerely,

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGED AND AGREED:

By: _____
[Authorized Representative of Medical Provider]

Date: _____