

Date: [Date]

To: [Medical Provider Name]

Address: [Provider Address]

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

RE: Fixed Balance Letter of Protection

Patient Name: [Patient Name]

Date of Loss/Injury: [Date of Incident]

Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

This letter serves as a formal Letter of Protection (LOP) regarding the medical services provided to the above-named patient. Our firm represents the patient in a legal claim for damages arising from the aforementioned date of loss.

In consideration of your continued medical treatment and/or the delay of immediate payment, we agree to protect your medical billings out of any settlement, judgment, or verdict obtained on behalf of the patient.

Fixed Balance Agreement:

It is mutually agreed that the total, final, and fixed balance for services rendered to date (or for the specific procedure: [Procedure Name]) is guaranteed at the set amount of: **\$(Dollar Amount)**.

This amount shall not be subject to further interest, late fees, or additional charges. Payment of this fixed amount will be made directly to your office from the proceeds of the patient's legal recovery prior to any distribution of net proceeds to the patient.

The patient remains ultimately responsible for the bill in the event there is no recovery; however, this letter guarantees that your office will be paid first from any funds received via settlement or judgment up to the fixed amount stated above.

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

Sincerely,

[Attorney Signature]

[Printed Name of Attorney]

[Law Firm Name]

Agreed and Accepted by Medical Provider:

Signature: _____ Date: _____

Printed Name/Title: _____