

[Attorney Name]
[Law Firm Name]
[Address]
[City, State, Zip Code]

[Date]

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

RE: LETTER OF PROTECTION / MAXIMUM DISBURSEMENT AGREEMENT

Patient Name: [Patient Name]
Date of Incident: [Date of Accident/Injury]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

This letter serves as a formal Letter of Protection regarding the medical treatment provided to our client, [Patient Name], for injuries sustained in the above-referenced incident. Our firm represents the patient in a legal claim for damages.

In consideration of your agreement to provide medical services on credit and to withhold immediate collection efforts, this office agrees to honor a lien against any settlement or judgment recovered on behalf of the patient. We will withhold from the proceeds of any recovery the amount necessary to satisfy your outstanding bills for services related to this specific incident.

Maximum Disbursement Clause:

Notwithstanding the above, please be advised that this Letter of Protection is subject to a maximum disbursement cap. In the event that the total recovery is insufficient to satisfy all outstanding medical liens, legal fees, and costs, this firm reserves the right to negotiate a pro-rata distribution of funds. Under no circumstances shall the total disbursement to your facility exceed \$[Enter Maximum Amount] or [Enter Percentage]% of the net recovery without prior written modification of this agreement.

Payment will be made directly to your office only upon the successful conclusion of the legal claim and the receipt of funds by this firm. The patient remains ultimately responsible for all medical charges if no recovery is obtained.

Please sign and return a copy of this letter to acknowledge your acceptance of these terms.

Sincerely,

[Attorney Signature]
[Printed Name of Attorney]

ACKNOWLEDGED AND AGREED:

By: _____
Authorized Representative for [Medical Provider Name]

Date: _____