Date: [Date]

[Physician Name]
[Clinic/Facility Name]
[Address]
[City, State, Zip Code]

RE: Letter of Protection, Lien, and Maximum Balance Agreement

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

To [Physician Name/Billing Department]:

This letter serves as a formal Letter of Protection (LOP) regarding the medical treatment provided to my client, [Patient Name], for injuries sustained in the above-referenced incident. My client is currently pursuing a legal claim for damages.

1. Letter of Protection and Lien: In consideration of your agreement to provide medical services on credit, my client hereby grants you a medical lien against any proceeds recovered through settlement, judgment, or verdict related to this claim. I am instructed by my client to withhold sufficient funds from any recovery to satisfy your outstanding medical bills before distributing the remaining balance to the client.

2. Maximum Balance Agreement: It is expressly understood and agreed that the total charges for the treatment of [Patient Name] related to this incident shall not exceed $[Amount]. Any charges incurred above this maximum balance will not be covered by this Letter of Protection and will remain the sole responsibility of the patient, or must be authorized in writing by this office prior to treatment.

3. Payment Terms: Payment will be issued directly to your office upon the final resolution and receipt of funds for this legal matter. Please provide this office with a final itemized statement and all relevant medical records upon the completion of treatment.

4. Notification: Please notify this office immediately if the patient fails to follow the recommended treatment plan or if there is a change in the estimated cost of care.

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

Sincerely,

[Attorney Signature]
[Attorney Name]
[Law Firm Name]

Acknowledgment and Agreement:

The undersigned physician/provider hereby accepts the terms of this Letter of Protection and Maximum Balance Agreement.

_____
[Physician/Authorized Representative Name]

Date: _____