Date: [Date]

To: [Medical Provider Name/Facility]
Address: [Provider Address]
City, State, Zip: [City, State, Zip]

RE: Letter of Protection for [Patient Name]
Date of Incident: [Date of Accident]
Claim Number: [Insurance Claim Number, if applicable]

Dear [Medical Provider or Billing Manager],

This letter serves as a formal Letter of Protection (LOP) regarding the medical services provided to my client, [Patient Name], for injuries sustained in the incident referenced above.

My office represents [Patient Name] in a legal claim for personal injury. In consideration for your agreement to provide medical treatment and defer collection of payment until the conclusion of the legal matter, this firm agrees to protect your financial interest in any settlement or judgment reached.

Conditional Maximum Balance:
Please be advised that this Letter of Protection is subject to a **Conditional Maximum Balance of $[Insert Dollar Amount]**. This office will not guarantee or protect any charges incurred by the patient that exceed this specific amount without prior written authorization and a formal amendment to this agreement.

Terms and Conditions:

- Payment is contingent upon the successful recovery of funds via settlement, judgment, or verdict.
- This firm is authorized to withhold the amount due (up to the maximum stated above) from any recovery proceeds.
- The patient remains ultimately responsible for the bill should there be no recovery or if the recovery is insufficient to cover all costs.
- You agree to provide this office with itemized billing statements and medical records related to this treatment upon request.

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

Sincerely,

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

Acknowleged and Agreed to by Provider:

Signature: _____ Date: _____

Printed Name/Title: _____