[Date]

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

RE: Letter of Protection with Maximum Cost Agreement

Patient Name: [Patient Name]
Date of Incident: [Date of Incident]
Our Case Number: [Case Number]

Dear [Provider Name or Billing Department],

This office represents the above-named client regarding injuries sustained in an incident on the date listed above. My client wishes to seek medical treatment with your facility.

By way of this Letter of Protection (LOP), we agree to protect your bill for reasonable and necessary medical services rendered to our client. Payment shall be made directly to your office out of any settlement, judgment, or recovery obtained in this matter.

Maximum Treatment Cost Limit:
Please be advised that this Letter of Protection is strictly limited to a maximum total cost of **$[Amount]**. Any treatment or services exceeding this specific dollar amount must be authorized by this office in writing. This office will not be responsible for protecting or paying any amounts in excess of this stated limit without a signed addendum.

By accepting this LOP, you agree to:

- Provide this office with copies of all medical records and itemized billing statements.
- Wait for payment until the conclusion of the legal claim.
- Cease any collection efforts against the patient personally while the claim is pending.

Please sign and return a copy of this letter to acknowledge your acceptance of these terms, specifically the maximum cost limitation.

Sincerely,

[Attorney Name]
[Law Firm Name]

Acknowledge and Agreed:

_____
[Provider Signature]

_____
[Date]