[Date]

[Surgical Center Name]
[Billing Department Address]
[City, State, Zip Code]

RE: Notice of Payment and Satisfaction of Letter of Protection

Patient Name: [Patient Full Name]
Date of Service: [Date of Surgery]
Account/Invoice Number: [Reference Number]
Our File Number: [Law Firm File Number]

Dear Billing Manager,

Please find enclosed a check in the amount of $[Amount] representing payment for the surgical services provided to the above-referenced patient.

This payment is issued in connection with the settlement of the patient's personal injury claim. This disbursement is intended to satisfy in full the Letter of Protection (LOP) previously issued by this office to your facility.

By accepting and negotiating this check, you acknowledge that the patient's outstanding balance for the aforementioned date of service is paid in full and that all liens or claims against the patient's legal recovery are hereby released.

Please update your records to show a zero balance for this account. If you have any questions regarding this payment, please contact our office immediately.

Sincerely,

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

Enclosure: Check #[Check Number]