Date: [Date]

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

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

To Whom It May Concern,

Please be advised that this office represents the above-named client regarding personal injuries sustained on the date referenced above. This letter serves as a formal **Letter of Protection (LOP)** concerning the medical services provided to our client.

In consideration for your agreement to provide medical treatment and to defer immediate payment until the conclusion of the client's legal claim, we hereby agree to protect your outstanding medical bills. We will withhold and pay directly to your office the necessary funds for such bills from any settlement, judgment, or recovery received on behalf of our client.

Please note that this letter does not guarantee the sufficiency of the settlement or judgment to cover all medical expenses, nor does it relieve the client of their ultimate personal responsibility for the debt should there be no recovery or an insufficient recovery. However, we guarantee that no funds will be disbursed to the client until your office's verified balance has been addressed from the proceeds of the case.

Please provide our office with copies of all medical records and itemized billing statements related to the treatment of our client as they become available.

Sincerely,

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

Acknowledge and Agreed:

_____
[Patient/Client Signature]