[Date]

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

RE: Letter of Protection and Lien Confirmation
Patient Name: [Patient Name]
Date of Incident: [Date of Accident/Injury]
Claim Number: [Insurance Claim Number, if applicable]

Dear [Medical Provider or Billing Manager],

This letter serves to confirm that this office represents [Patient Name] in a legal claim for personal injuries sustained on the date referenced above.

Our client is seeking medical treatment from your facility. In consideration for your agreement to provide medical services on credit, our client hereby grants you a lien on any settlement or judgment recovered as a result of this claim. We acknowledge this Letter of Protection (LOP) and agree to withhold funds from any recovery to satisfy your reasonable and necessary medical charges related to this incident.

Please note the following conditions:

- This lien applies only to charges directly related to the injuries sustained in the incident mentioned above.
- Payment is contingent upon a successful recovery (settlement or verdict).
- Our office must be provided with final itemized billing statements and medical records upon the conclusion of treatment.

By accepting this letter, you agree to exhaust all available health insurance or Med-Pay coverage before seeking payment through this lien, where applicable.

Please sign below to acknowledge your acceptance of this Letter of Protection and return a copy to our office.

Sincerely,

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

ACKNOWLEDGMENT AND AGREEMENT

I, the undersigned patient, hereby authorize and direct my attorney to pay the medical provider directly from the proceeds of any settlement or judgment.

_____
[Patient Signature] Date: [Date]

Accepted by Medical Provider:

_____
[Authorized Representative] Date: [Date]