[Date]

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

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

Dear **[Contact Person or Billing Department]**,

Please be advised that this office represents **[Patient Name]** regarding legal claims arising from injuries sustained on **[Date of Incident]**. Our client is seeking medical treatment from your facility for these injuries.

This letter serves as a **Letter of Protection**. In consideration of your agreement to provide medical services to our client on credit and to forego immediate collection efforts, we agree to protect your outstanding medical bills from any settlement, judgment, or verdict recovered on behalf of our client related to this specific matter.

By accepting this letter, you agree to:

- Provide all necessary medical treatment to our client.
- Withhold any collection actions or reporting to credit agencies pending the resolution of the legal claim.
- Provide this office with copies of all medical records and itemized billing statements upon request.

Please note that this letter is not a guarantee of payment from this firm's own funds, but rather a lien against the proceeds of any recovery. Payment will be made directly to your office at the time of the final distribution of settlement or judgment funds.

Please sign and return a copy of this letter to acknowledge your acceptance of these terms.

Sincerely,

[Attorney Name/Law Firm Name]
[Phone Number]
[Email Address]

ACKNOWLEDGMENT AND ACCEPTANCE:

I, **[Patient Name]**, hereby authorize and direct my attorney to pay the above-named provider directly from any settlement or judgment proceeds.

____
Patient Signature

The undersigned provider hereby accepts the terms of this Letter of Protection.

____
Provider Representative Signature