LETTER OF PROTECTION

DATE: [Date]

TO:
[Imaging Facility Name]
[Facility Address]
[City, State, Zip Code]

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

To Whom It May Concern,

Please be advised that this office represents the above-named patient regarding injuries sustained in an incident on the date listed above. We understand that your facility is an out-of-network provider for the patient's insurance or that the patient is currently uninsured for these services.

This letter shall serve as a Letter of Protection regarding the diagnostic imaging services (MRI, CT, X-Ray, etc.) provided to our client. In consideration for your agreement to provide medical services on credit, we hereby agree to protect your outstanding balance for these specific services from any settlement, judgment, or verdict received by our client as a result of their legal claim.

By accepting this Letter of Protection, you agree to:

- Withhold any collection efforts against the patient personally until the legal claim is resolved.
- Provide this office with a copy of the final itemized billing statement and the formal imaging reports.

This office is directed to pay your facility directly from the proceeds of any recovery before any funds are distributed to the client. This agreement does not guarantee payment if there is no recovery, but it ensures priority payment upon a successful resolution of the case.

Please sign below and return a copy to our office to confirm your acceptance of these terms.

Sincerely,

[Attorney Name]
[Law Firm Name]

ACKNOWLEDGMENT & AGREEMENT

I, the patient, hereby authorize my attorney to pay the diagnostic provider directly from my settlement. I understand I remain ultimately responsible for the bill if no recovery is made.

_____
[Patient Signature]

Accepted by Imaging Facility Representative:

_____
[Facility Representative Signature]