[Date]

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

RE: Letter of Protection

Patient Name: [Patient Full Name]
Date of Loss/Injury: [Date of Incident]
Claim Number: [Insurance Claim Number, if applicable]

To Whom It May Concern,

Please be advised that this office represents **[Patient Name]** in a legal claim for personal injuries sustained on or about **[Date of Incident]**. We understand that your facility is an out-of-network provider for our client's insurance, or that the client is currently unable to pay for pain management services out-of-pocket.

This document serves as a Letter of Protection. In consideration of your agreement to provide medical evaluation, pain management treatments, and/or procedures on a credit basis, we hereby agree to withhold and pay to your office such sums as may be due and owing for medical services rendered to our client directly from any settlement, judgment, or verdict received in this matter.

Please note that this letter does not guarantee the amount of the recovery, but ensures that your bills will be paid from the proceeds of the case before any remaining funds are distributed to the client. We further request that you provide this office with copies of all medical records and itemized billing statements related to the treatment of our client as they become available.

Payment will be made to your office upon the final resolution and receipt of funds regarding this legal claim.

Sincerely,

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

Acknowledgment and Agreement:

I, **[Patient Name]**, hereby authorize my attorney to pay the above-named provider directly from the proceeds of my legal claim. I understand that I remains ultimately responsible for the payment of my medical bills regardless of the outcome of my legal case.

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[Patient Signature]