

[Date]

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

RE: Letter of Protection / Formal Assignment of Benefits  
Patient/Minor: [Minor's Full Name]  
Parent/Guardian: [Parent/Guardian Name]  
Date of Incident: [Date of Accident]  
Your Account #: [Account Number]

To Whom It May Concern:

This office represents the above-named minor and their parent/guardian in a legal claim for personal injuries sustained on the date referenced above.

Please be advised that this letter serves as a Letter of Protection. We request that you provide all necessary medical treatment to the minor patient and withhold collection efforts against the minor or their guardians until the conclusion of the legal claim. In exchange, our office agrees to protect your outstanding medical bills from any settlement or judgment proceeds received on behalf of the minor.

This agreement is subject to the following conditions:

- The total amount paid shall not exceed the reasonable and customary charges for the services provided.
- Payment is contingent upon the successful recovery of funds through settlement or trial.
- Any final distribution of funds for a minor may require approval by the Court.

By accepting this letter, you agree to look solely to the proceeds of the legal claim for payment and to cease any active collection or credit reporting activities during the pendency of this case. Please provide us with a complete set of medical records and itemized billing statements for our file.

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

Sincerely,

[Attorney Name]  
[Law Firm Name]

**ACCEPTED AND AGREED TO:**

By: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_