[Sender Name/Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

**RE: Letter of Protection and Assignment of Benefits**
**Patient Name:** [Patient/Client Name]
**Date of Loss/Injury:** [Date]
**Claim Number:** [Claim Number, if applicable]

To Whom It May Concern,

Please be advised that this office represents the above-named client in a claim for personal injuries sustained on the date referenced above. This letter serves as a formal Letter of Protection (LOP) regarding the medical services provided to our client.

We hereby agree to honor your medical lien and will withhold sufficient funds from any settlement, judgment, or recovery received in this matter to satisfy the outstanding balance for services rendered to our client. These funds will be held in our Attorney Trust Account and disbursed directly to your office at the time of the final settlement of the legal claim.

Please note that this letter does not guarantee the outcome of the legal matter or the sufficiency of the recovery to cover all liens. However, we agree to notify you of the conclusion of the case and to protect your interest in the proceeds as stated herein.

Our client has authorized and directed us to pay your bill directly from the trust account proceeds. A signature from the client acknowledging this assignment is included below.

Please provide us with a final itemized statement and all relevant medical records for our file.

Sincerely,

[Attorney Signature]
[Printed Name of Attorney]

**CLIENT ACKNOWLEDGMENT**

I hereby authorize my attorney to pay the above-named provider directly from any settlement or judgment proceeds received in my case. I understand that I remain personally liable for any balance not covered by the legal recovery.

_____

[Client Signature]
[Date]