ATTORNEY LETTER OF PROTECTION

Notice to Attorney: _____

Reference: Your Client /Our Patient: _____

Date of Accident: _____ Claim Number: _____

I / My Facility has rendered or is rendering medical services to the above -mentioned patient. Our Patient/Your Client has authorized, and directs, by his/her signature below, that you, as the attorney on this case, protect our outstanding bill for services arising out of this accident by withholding such sums from any settlement, judgment, verdict or other sources, that may become available to protect Me/My Facility's outstanding bills, by making direct payment for our bills, to Me/My Facility, when, and should a settlement occur.

We understand that this is providing the settlement is adequate to cover all or an equal percentage, of our outstanding medical bills, and all other protected bills and legal fees. Patient/Client and I understand that, should not enough arise out of the settlement, or should you not be able to obtain a settlement for whatever reason, Patient/Client shall be solely responsible for all outstanding balances with Me/My Facility.

I / My Facility realizes that as long as litigation is in process for this accident, and as long as this Patient/Client remains a Client with You/Your Firm, we will not initiate any collection proceedings for any unpaid balances until the case has been resolved. I understand to do so, would void this Letter of Protection. Patient hereby agrees that should for any reason, your services, or that of your firm, be suspended, I/My Facility may then begin collection proceedings immediately, unless patient obtains a letter of protection from another law firm immediately.

I / My Facility will cooperate with you in any manner possible, including making available to you, upon request, copies of any and all bills, and documentation reflecting treatment on this Patient / Client for which payment is expected out of this settlement.

I / My Facility, the undersigned Patient / Client, and Attorney, hereby agrees to observe all of the above terms and conditions.

Patient/Client: _____ **Phone:**_____

Patient's Address: _____**Fax:** _____

Patient/Client Signature: _____ **Date:** _____/_____/_____

Attorney/Firm: _____

Attorney Signature: _____**Date:**/_____/_____/_____

Phone #: _____ **Fax:** _____

Firm Address: City: _____**State:** _____ **Zip:** _____

Therapist: _____**Phone:**_____ **Lic#:** _____

Therapist Address:_____**State:**_____**Zip:**_____

Therapist Signature: _____**DATE:** ____/_____/_____