Letter of Protection

Patient Name: (Last) ______________________________ (First) ______________________________________

Address: ____

____

Phone #: (____) ________________________________   SS # ________/________/________

Date of Injury: ________/________/________

Attorney Name: ____

Address: ____

____

Phone #: (_____) _______________________________   Fax #: (_____) ________________________________

Attorney ______________________________ is requested and authorized to pay Advanced Injury Treatment Center any monies due on account number ____________________. All monies are to be deducted from any medical payments; settlement made on my behalf or my no fault benefits.

If there is any difference between the total amount Advanced Injury Treatment Center charges and the amount paid to them by my attorney or any insurance company, I agree to pay Advanced Injury Treatment Center the difference.

Further, I understand and agree to pay Advanced Injury Treatment Center their full amount of charges should the care or my treatment thereof be such that it is not covered by any policy or insurance, of it for any reason the insurance refuses to pay, or this matter is not decided in my favor.

I authorize my attorney to pay Advanced Injury Treatment Center the balance of its bill as he / she received payment of medical benefits and the final balance when my case is settled.

Patient Signature: _____________________________________ Date: __________________________

I, Attorney _____________________________________ assent to this agreement on ________________