



LETTER OF PROTECTION - Regarding Medical Bills and Medical Reports

_____, ESQ.

Patient Name _____

Date Of Accident: _____

Account # _____

Ph: _____

File # _____

Fax: _____

Date: _____

I, the undersigned, hereby agree that this agreement constitutes a lien against any recovery of proceeds paid by any insurance carrier or from whatever source, settlement, judgment or verdict which may be paid to my attorney or myself as a result of the injuries by reason of this accident.

I hereby authorize my attorney to discuss my case or provide Central Medical Imaging with any information necessary to have payment paid directly to them for such sums as may be due and owing for medical services rendered me. I, furthermore, authorize my attorney to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay Central Medical Imaging as soon as possible for said debt.

I, _____, fully understand that I am directly responsible to Central Medical Imaging for all medical bills for services rendered me and this agreement does not relieve me of any personal responsibility for said charges. I further understand that this agreement is made solely for the protection of said provider and such payment is not contingent on any settlement, judgment or verdict, which I may recover, said fee.

I understand that this letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute attorney at any future time. I further understand and agree to notify Central Medical Imaging in writing if I change or terminate attorney/client relationship

PATIENT SIGNATURE: _____ DATE: _____

I, the undersigned being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay Central Medical Imaging as soon as possible for said debt.

I, furthermore, understand and agree to immediately notify Central Medical Imaging in writing should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

ATTORNEY SIGNATURE: _____ DATE: _____