RELEASE OF AUTHORIZATION
AND
LETTER OF PROTECTION

I, _____, hereby authorize this office to furnish my attorney, _____, and/or_____ Insurance Company, or the designee of either, any medical information requested concerning the condition or treatment of injuries sustained by me and/or my children, on _____.

I authorize and direct my attorney to pay from any insurance or other proceeds for any recovery made as a result of said injury; any unpaid balance due said doctor for professional services as a result of any treatment to myself, or my children. I understand that this in no way relieves me of my personal primary responsibility to pay my doctor for service when a statement is rendered and that I will receive customary billing for said services.

I authorize my attorney or any third party liability carrier to disclose the settlement status, settlement statement and/or a copy of the settlement check if requested for our purposes. At the time of the settlement, the attorney is instructed that this office shall be furnished separate checks for the medical services which they have rendered for full balance due at that time.

Upon settlement of the underlying, the attorney's office will disburse funds directly to Dr.Nailah Smith. The patient hereby acknowledges that should the net recovery to the patient not be sufficient to pay in full all amounts due this office with respect to the above stated matter, then the patient shall remain personally responsible for any unpaid balance.

1. I understand that I am being treated for injuries sustained in a motor vehicle accident, personal injury and or workman's compensation injury and that failure to keep my appointments may jeopardize the insurance carrier's responsibility for medical costs and/or compensation for pain and suffering.
2. I understand that this office is extending me credit for treatment and that if I miss two (2) office visits without a reasonable excuse all bills may be due immediately.
3. I understand that if I sever ties with my attorney before settlement or my attorney will no longer represent my case, all bills may be due immediately.
4. Once released from care, if my case is not settled within six months I will begin making payments of $25.00 a month to this office toward my bill.
5. If my bill is not paid within 10 days after the settlement, my balance will then be doubled.
6. I further understand that if my account is placed in collection status for non-payment or forwarded to a collection agency that I will be assessed a fee of 33% of my current balance.
7. No bills and/or records will be released until patient balance has a zero balance, as our office is extending our services as a credit until a final settlement is met. Therefore, all medical records and bills are the property of Full Body Rejuvenation Center, until the patient's balance is paid in full.

PATIENTS SIGNATURE_____DATE_____
SOCIAL SECURITY #_____

FULL BODY REJUVENATION CENTER
3636 Panola Rd. Suite B, Lithonia, GA 30038
770-733-1381