Lien/Letter of Protection

Date: _____

To: Name of Attorney:
Phone Number:
Address:
Fax Number:

Re: Patient Name:	DOB:
Address:	SS #:
Home Phone#:	Cell Number#:
Minor(s) Involved:	Date of accident:

Dear Attorney:

We understand that your law firm represents _____(referred to as "patient" or "client" herein) who was injured in a _____(date)_____ incident. We also understand that due to financial difficulties caused by this incident, the patient is unable to pay for all of our services and that automobile insurance or some other incident related insurance will be used to pay your client's medical bills. If this is the situation, please sign and deliver the enclosed Agreement that obligates you to protect payment of your client's medical bills incurred with this office for medical treatment out of any recovery, settlement, judgment, or verdict, obtained on your client's behalf.

Please note that part of the Agreement requires full disclosure to us of all sources of automobile insurance or some other incident related insurance that you are attempting to recover on behalf of your client.

Please note that this office will not schedule any appointments with your client until we receive the executed Agreement.

Sincerely,

_____

Doctor Signature

AGREEMENT

This agreement is made between Full Body Rejuvenation Center ("medical provider" herein), the law firm of _____ ("law firm" herein) and _____ ("patient" or "client" herein). The law firm represents the client who was injured in an incident that occurred on _____. Due to financial difficulties caused by this incident, the patient is unable to pay the medical provider for its services and that automobile insurance or some other incident related insurance will be used to pay the client's medical bills. Therefore, the patient has authorized the law firm to withhold sufficient funds from any recovery obtained on the patient's behalf to pay the medical provider's bill if it agrees not to attempt to collect the balance until the case is resolved.

The law firm will "protect" the medical provider's bill arising from medical services they provided, or do provide, for injuries that resulted in the injury claim the law firm is handling for the client.

Conditions of Protection:

1. If the law firm receives funds from any recovery made, whether by settlement or judgment, the law firm will ask the medical provider to provide a written statement of the outstanding balance if one is not on file.

2. The medical provider agrees to notify the law firm in writing of the outstanding balance, and if the client approves the amount, the law firm will pay the medical provider directly.

3. If the client objects to the bill, then the law firm will place an amount sufficient to pay the entire bill in its trust account. The law firm will hold the funds until the medical provider and the client/patient jointly direct disbursal or a Court of competent jurisdiction orders the disbursal.

4. The undersigned attorney or another attorney in that law firm agrees to negotiate directly with the medical provider regarding any requests for reduction of an outstanding bill. Furthermore, the undersigned patient/client agrees to not attempt to negotiate with the medical provider regarding that patient/client's outstanding bill, but agrees that his/her attorney will be solely responsible for negotiating with the medical provider for billing matters.

5. The patient/client agrees that he/she is responsible for payment of any outstanding bills with the medical provider, regardless of other payments the medical provider may have received from other collateral sources. This condition is a material term to this Agreement. By signing below, the patient/client agrees that he/she is responsible for payment in full of any outstanding bills incurred with the medical provider and it is completely discretionary on the part of the medical provider to agree to reduce the balance of any patient/client outstanding bills.

6. If the patient is provided medical or health insurance, including Medicare, patient agrees it is the sole discretion of the medical provider whether to bill the patient's health insurance carrier or to elect to receive payment pursuant to this Agreement.

Fees for Medical Care and Treatment:

1. The medical provider agrees that the law firm will not be personally obligated to pay for charges arising from treatment of the patient.

2. The law firm agrees to pay the medical provider for assisting the law firm's representation of the client/patient, including payment for medical reports, copies of records, testimony at deposition or trial, necessary research or study to prepare for a deposition or trial (if requested by the law firm), and the cost of examinations of the client at the law firm's request. While the law firm agrees to pay for these services, the law firm will bill the client/patient for the amount the law firm pays on the behalf of the client.

Insurance Disclosure, Disclosure of Medical Bills and Remaining Benefits:
(Completed by the Law Firm)

TO:

ATTN:

FROM:

DATE:

RE:

PLEASE FAX OR EMAIL THIS FORM TO:
FAX: 866-762-9112
Email: fullbodyfax@gmail.com

It is our understanding that this patient has a pending legal claim, and that our bill for providing these services will be protected from any recovery the patient receives at the conclusion of their case. Please return this form with the "Letter of Protection" and asks that you complete the questionnaire below.

1. Do you have a police report for this client? □ Yes □ No. **Please attach with response**
2. Does the client have pre-existing conditions? □ Yes □ No
3. What type of accident do you represent the patient for?

□ **Auto Accident** □ **Slip and Fall** □ **Workers' Compensation** □ **Other Negligence**

4. Would you characterize liability as? □ Good □ Bad □ Comparative Negligence

5. Have you confirmed coverage to compensate your client for their damages? □ Yes □ No

6. Would you characterize property damage as**?**
□ **Total Loss** □ **Heavy** □ **Medium** □ **Light** □ **Under $1000.00**

7. What is the amount of coverage available to compensate your client?
BI: □ **25/50** □ **50/100** □ **100/300** □ **250/500** □ **1mil+**

UM: □ **25/50** □ **50/100** □ **100/300** □ **250/500**
□ **Add on** □ **Reduced**

LIABILITY CARRIER & CLAIM #:_____

MEDPAY/PIP □**Yes** □**No** **Amount**_____
Adjuster:_____

Carrier and claim #:_____
Phone #:_____

8. What is the current status of this case? □ Investigation □ Pre-suit Negotiations □ Litigation

Thank you for taking the time to complete this questionnaire and returning the same. We ask that you sign this letter, which confirms your intent to protect Full Body Rejuvenation Center at the time a settlement, verdict or recovery is reached.

Total amount of medical bills the patient/client has incurred to date: _____
Total Remaining Personal Injury Protection/No-Fault Balance: _____
Total Remaining Automobile Medical Payments Coverage Benefits: _____

By signing below, you agree to the above terms and conditions, affirm the information provided herein is accurate and true to the best of your knowledge, and are signing this Agreement voluntarily.

_____
Attorney Printed Name

_____
Attorney Signature

_____
Date

I hereby authorize my attorney to pay Full Body Rejuvenation Center from the proceeds of my pending legal claim. I understand that Full Body Rejuvenation Center is providing services with no pre-payment based on assurance from me and the assurance from my attorney that the charges for health care services will be reimbursed in the event a settlement, verdict or financial recovery is reached.

_____
Patient/Client Printed Name

_____
Patient/Client Signature

_____
Date

Dr. Nailah Smith
Physician Printed Name

_____
Physician Signature

_____
Date