



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, or if 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 _____