Protection from Attorney

Certified Return Receipt Number: ____________

Patient: ____________
Claim Number: ____________
Date of Accident: ____________
Attorney's Name: ____________
Firm: ____________
Address: ____________
Phone Number: ____________
Fax Number: ____________

deBarros Chiropractic Clinic, P.C.
7020 Cold Harbor Road
Mechanicsville, VA 23111
Ph: 804-730-2609 Fax: 804/730-6496

Please accept my signature below as authorization and direction to you, my attorney, to DIRECTLY pay then above-listed physician any unpaid balances due from any settlement, judgment, or verdict, for any and all services rendered to me in my care and treatment and efforts to collect remedies, for injuries sustained by me on Date(s): ____________

Professional; treatments and services, including those for treatments heretofore and thereafter rendered, as well as for any reports, copying fees; (and any monies /balances due from prepaid depositions, court appearances or standby for court appearance fees) are to be paid DIRECTLY to the physician within three (3) days of receipt by you of settlement or recovery. Bills for services rendered automatically take precedence over any settlement for wages. All monies in dispute will be held in escrow. Any collection attempts, fees and/or costs incurred by the physician will also be covered by this letter of protection.

I agree to promptly notify the above mentioned physician of any change of attorney(s) used by me with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such subtitled or added attorney(s).

I understand that this does not relieve me, the undersigned patient, of my personal responsibility for all such charges in the even of failure to recover.

Upon signature, the undersigned patient and attorney do hereby agree to observe all the above terms and covenants. Furthermore, the attorney agrees to withhold such sums from ay settlements, judgments, verdicts or other sources that may become available to protect the physician's outstanding bill.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due payable.

I have read and understand the above.
Patient Signature: ____________ Date: ____________

Attorney Instructions: Please sign, date, notarize and return one copy to this office within five (5) business days of Date: ____________
Reply envelope enclosed. Thank you.

Attorney Name (Print): ____________ Date: ____________
Attorney Signature: ____________

Notary Signature: ____________ Date: ____________
My Commission expires: ____________