

MVA LETTER OF PROTECTION



Patient Name: _____

Date: _____

As consideration for therapeutic services received, I hereby irrevocably assign to Focus Physical Therapy, Inc., (hereinafter referred to as "Focus") out of the proceeds that would otherwise be payable to me out of any settlement, judgment or other recovery from my claim for personal injuries which occurred on _____ (Date of Accident), such sums sufficient to pay in full all amounts I owe to the Clinic for my care for those injuries.

I direct my attorney, _____ (Name) to pay the Clinic directly out of the proceeds of any settlement or recovery, after paying attorney fees and costs and any valid hospital lien, any and all amounts I owe to the Clinic for care provided for my injuries. I understand that this means that before any proceeds are paid to me my attorney will pay directly to the Clinic the amount necessary to pay any outstanding amount I owe the Clinic for my care. I further agree not to rescind this agreement and instruct my attorney not to honor any attempt by me to rescind this agreement.

I understand and agree that I am directly and fully responsible to pay the Clinic for all services provided to me. I am entering into this agreement to provide the Clinic additional protection for payment of my outstanding bill and in consideration of Clinic's forbearance of immediate payment. I also understand that in the event that I do not receive a settlement or recovery in my personal injury case, or if the amount is not enough to pay all fees, costs and outstanding bills, I am still personally responsible to pay the Clinic for all amounts I still owe.

If my balance reaches \$5,000 I agree to make payment in full for each visit so that my outstanding balance does not exceed \$5,000. If my case has not been settled at the time of my discharge from care, I agree to make additional monthly payments of a minimum of \$35.00 or 8.5% of the balance, whichever is greater, to the Clinic until such time as my case has been settled or until the balance of my bill has been paid in full.

Both Patient and Attorney are Required to Sign:

Dated

Signature of Patient

Print Name

Driver's License Number

Date of Birth

As the Attorney of record for the above patient, I agree to observe the terms of this agreement and to act in accordance with the agreement between the Clinic and my client by paying directly from the proceeds of any settlement, judgment or recovery that patient is entitled to receive after attorney fees and costs and any valid hospital liens are paid.

Dated

Signature of Attorney

Street Address

City, State, ZIP

Phone Number

ATTORNEY: Please date, sign and return original copy to:

Focus Physical Therapy, Inc.
901 NW Carlon Avenue, Suite 3
Bend, OR 97701
541-385-3344 Phone
541-312-5256 FAX