LETTER OF PROTECTION

Attorney Name:_____ Date: _____
Attorney Address: _____ Attorney Fax: _____
Attorney Phone:_____ DOA: _____
Patient Name: _____ DOB: _____
Exam: _____

I, the undersigned, hereby agree that this agreement constitutes a lien against any recovery of or from whatever source, settlement, judgment, or verdict which may be paid to my attorney, or myself as a result of the injuries by reason of this accident.

I hereby authorize my attorney to provide Advanced Radiology with any information necessary to have payment paid directly to them for such sums as may be due and owing for medical services rendered to me. I, furthermore, direct my attorney to pay such sums from any source, settlement, judgement, or verdict and remit payment to Advanced Radiology within 30 days of receipt of settlement or final resolution of matter.

I, PATIENTS NAME, fully understand that I remain responsible to settle my financial obligations to Advanced Radiology for all medical bills for services rendered to me and this agreement does not relieve me of any personal responsibility for said charges. I further understand I am forfeiting the right to use my medical health insurance, or any other type of insurance for services related to the accident covered under this Letter of Protection and that this agreement is made solely for the protections of said provider and such payment is not contingent on any settlement, judgement, or verdict by which I may recover said fees.

I understand that this Letter of Protection is irrevocable and shall apply to cause of action whether or not I should engage legal counsel or substitute attorney at any future time. I further understand and agree to notify Advanced Radiology Partners in writing if I change, terminate any attorney/client relationship.

A case status update will be provided upon request. If there is no reply in 30 days, I will be financially responsible.

PATIENT SIGNATURE: _____ DATE: _____

I agree to provide notice to Advanced Radiology in writing immediately upon final resolution of this matter, and/or at the time of occurrence of the following events: substitution of counsel, referral to another attorney, or law firm, retention of co-counsel, or should the attorney/client relationship be terminated or modified in any manner.

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any source, settlement, judgment, or verdict and pay Advanced Radiology within 30 days of receipt of settlement or final resolution of matter.

ATTORNEY SIGNATURE: _____ DATE: _____

Medical.records@adrad.com **wclop@adrad.com** **Billing; www.chartswap.com**

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