Clinical Massage Therapy

CMT Rocklin
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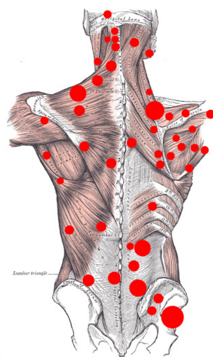

CMT Folsom
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CONTRACTUAL GUARANTEE OF PAYMENT FOR MEDICAL SERVICES

I hereby authorize and direct you, my attorney, to pay directly to my health care provider, Clinical Massage Therapy, the total dollar amount owing for health care services, including applicable interest charges, provided for injuries arising from the motor vehicle accident on _________. I hereby authorize my attorney and the involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect my health care provider and their office. Thereby further consent to a lien being filed on my case by said health care provider and their office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or me as the result of the injuries for which I have been treated.

I agree never to rescind this document and that any attempt at recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said health care provider or their office for all health care bills submitted by them for services rendered to me. Further, this agreement is made solely for said health care providers' additional protection and in consideration of their forbearance on payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages.

I specifically request my attorney to acknowledge this letter by signing below and returning it to the office of Clinical Massage Therapy. I have been advised that if my attorney does not wish to cooperate in protecting the health care providers' interest, the health care provider will not await payment, but will require me to make payments on a current basis.

Date _______________ Patient's Signature ____

Patient's Social Security Number or Driver's License Number __________________________________

The undersigned, being attorney of record for the above patient, does herby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said health care provider named above.

Date _______________ Attorney's Signature ____

Please date and sign and return an original executed copy to Clinical Massage Therapy