

LETTER OF PROTECTION

The purpose of this document is to provide a courtesy to our patient who requires services but is not able to afford the prescribed care. A patient receiving care in our facility is ultimately responsible for payment of services rendered, however, we will extend a courtesy of time if the patient cannot afford deductibles, reductions, or services in excess of the insurance coverage. This courtesy is extended to those patients who are compliant with recommendations and are injured due to the fault of another.

I, _____, (hereafter patient) hereby authorize my attorney, _____ (hereafter attorney) to disburse direct to Joseph P. Hornberger, M.S.,D.C.,P.A. (hereafter corp.) any and all sums necessary to pay any outstanding balance due on the doctor's bill for care and treatment rendered to me, from any net proceeds recovered in my behalf by attorney as a result of any insurance contract claims or personal injury claims prepared and handled on my behalf by attorney for injury dated _____.

This letter is binding not only upon the above named attorney but any successor attorney(s) in the event that patient elects to change attorney during the pendency of said claims. A copy of **Assignment, Lien and Authorization** form on file with Joseph P. Hornberger, M.S.,D.C.,P.A. is enclosed for attorney file.

Doctor is hereby authorized to deliver copies of this letter of protection to my above named attorney or any successor attorney for his/her signature and acknowledgment. I hereby request and direct my attorney to sign this letter of protection acknowledging that he/she will abide by the terms of this letter of protection received in my behalf.

By signing below, I hereby acknowledge that the doctor's forbearance in the receipt of payment for medical services rendered even though some or all of said medical/dental services may be reimbursed by other available insurance benefits is good, valuable, and sufficient consideration for the promises contained herein from myself and attorney.

Dated this _____ day of _____, 20____.

Patient: _____ Witness: _____

By signature below, I acknowledge receipt of the above **ASSIGNMENT, LIEN AND AUTHORIZATION** issued to **JOSEPH P. HORNBERGER, M.S.,D.C.,P.A.**, by _____ and agree to abide by the terms of this letter of protection.

I further agree to distribute funds received to Joseph P. Hornberger, M.S.,D.C.,P.A. in accordance with these terms and applicable Florida law.

Dated this _____ day of _____, 20__.

Attorney At Law

Letter of protection
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