MAIL TO SELF

Patient Name: Date:

As consideration for medical services received, I hereby irrevocably assign to [Name of Clinic] out of the proceeds from the settlement, judgment, or any recovery from my claim. It will be for medical services for the private injuries which occurred on (Date of Accident). The sum of the settlement will be sufficient to pay fully all amounts I owe to the Clinic for my care for those injuries.

I authorize my attorney, (Name) to pay the Clinic directly out of the proceeds of any settlement or recovery. The payment will be for any and all amounts I owe to the Clinic for treatments provided for my injuries. It'll be after paying attorney fees and costs and any valid hospital lien. I understand that this suggests my attorney will ensure to pay the Clinic the outstanding amount that I owe for the treatment provided. After that amount is paid, I can receive my proceeds. I further concur to not annul this agreement and direct my attorney not to honor any of my attempts to annul this agreement.

I understand and agree that I'm directly and entirely responsible to pay the Clinic for all treatments provided to me. I am getting into this agreement to offer the Clinic additional protection for payment of my outstanding bill and in consideration of the Clinic's forbearance of immediate payment. I also understand that might not receive a settlement or recovery in my personal injury case. The amount that I receive might also be lesser than was I was seeking. If the amount is lesser than all fees, costs, and outstanding bills, I will be still personally responsible to pay the Clinic for all amounts I owe.

If my balance reaches [amount] I agree to make payment in full for each visit so that my outstanding balance does not exceed [amount]. My case might not be settled at the time of my discharge from care. In that scenario, I agree to make additional monthly payments of a minimum of $35.00 or 8.5% of the balance, whichever is bigger to the Clinic. It will be until the time my case has been settled or until the balance of my bill has been paid in its entirety.

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 comply with the terms of this agreement. I will act in accordance with the agreement between the Clinic and my client. It will be by paying directly from the proceeds of any settlement, judgment, or recovery that [client's name] is entitled to receive. The payment will be made 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 the original copy to:

[Name of Clinic/ Hospital]

[Address of Clinic/ Hospital]