



18927 33rd Ave W Suite B, Lynnwood, WA 98036
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Contractual Guarantee of Payment for Health Care Services

I hereby authorize and direct you, my attorney, to pay directly to BALANCED BODY MASSAGE THERAPY such sums as may be due and owing: date of loss _____, for health care services for injuries arising from a motor vehicle accident. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgement, or verdict as may be necessary to adequately protect said office/ I hereby further consent to a lien being filed on my case by said office against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or me as a result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempt to rescind this document will not be honored by my attorney. I hereby instruct that in the even 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 office for all health care bills submitted for services rendered to me. Further, this agreement is made solely for said office's additional protection and in consideration of forbearance on payment. I understand that said payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages. Also, I understand that my responsibility to pay (the office's) bill is independent and separate from (the office's) right to file a lien to protect it's financial interests under RCW 60.44.

I specifically request my attorney to acknowledge this letter by signing below and returning it to Balanced Body Massage Therapy. I have been advised that if my attorney does not wish to cooperate in protecting the office's interests, the office will not await payment, but will require me to make payments on a current basis as determined by Balanced Body Massage Therapy. With balances over 90 days I will pay interest at 1% per month (12% annually).

PATIENT SIGNATURE

DATE

PATIENT'S DRIVERS LICENSE #

PATIENT'S SOCIAL SEC. NUMBER

The undersigned, being my attorney of record for the above patient, does hereby agree to observe all of 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 office named above.

ATTORNEY SIGNATURE

DATE

Please date, sign and return to: **Balanced Body Massage Therapy**