Atlantic Rehabilitation Center

Physical Therapy
Occupational Therapy
Athletic/Personal Training
Performance Training
Massage

Patient Name: Accident date:

Dear Sir/Madam:

This is our "Letter of Protection" which outlines the terms of payment for any treatment Atlantic Rehabilitation Center, Corp., (ARC) provides to your client, (_____). arising out of or in any way related to the above-referenced accident (_____). We are asking the client to execute this letter as well. If the client recovers money damages from any person or entity responsible for the charges incurred by the client with ARC, you agree to withhold from any check or draft in which you are an additional named payee sufficient funds, after deduction of attorneys' fees and costs, to pay any outstanding medical bills in your possession for any and all charges owed to ARC in connection with the accident. ARC will furnish you with periodic updates of outstanding charges upon your request.

ARC will bill the client's PIP or Liability Insurance Carrier initially (when applicable). Any remaining balance shall be billed to the client's health insurance payer. If the net recovery to the client (defined as the amount, after deduction of attorneys' fees and costs, of settlement or court award) is less than the total outstanding charges owed to all health care providers covered by a statutory lien or a letter of protection, such funds will be distributed to all providers on a pro rata basis. The client further agrees to remain fully responsible to pay for ARC's services even if there is no recovery from the Accident, or a recovery of less than the full amount due.

The client agrees to not challenge or otherwise interfere with payments made by the client's attorney to ARC out of the client's net recovery. In the event that the client challenges or otherwise interferes with payment to ARC, the client agrees to pay ARC's reasonable collection costs, including attorney's fees, incurred by ARC in collecting payment for services rendered to the client.

This agreement becomes effective when signed by ARC, you, and the client. Each provision of this Letter of Protection shall be considered severable; and if, for any reason, any provision or provisions herein are determined to be invalid and contrary to any existing or future law, such invalidity shall not impair the operation of or affect those portions of this Letter of Protection which are valid.

Sincerely,
Atlantic Rehabilitation Center, Corp.

By _____
Print Name: Wanda Sanchez
Title: Clinic Administrator

Please choose ONE of the following:

Patient has medical insurance: Remit any Letters of Exhaustation

Insurance Company: _____

ID #: _____

Patient has "NO other insurance": Patient Signature: _____

Agreed and Consented to:

Attorney and/or Rep Name: _____

Attorney and/or Rep Name Signature: _____

Email: _____

Address: _____

Telephone#: **Fax#:**

Main Office
16249 Biscayne Boulevard
North Miami Beach, FL 33160

Pembroke Pines Office
17842 NW 2nd Street
Pembroke Pines, FL 33029

Davie Office
11870 West State Road 84, Bldg. C-3
Davie, FL 33325

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