LETTER OF PROTECTION

Patients Name: _____	Name of Attorney: _____
Patient Address: _____ _____	Attorney Address: _____ _____
Patient Phone Number: _____ Alternate Phone Number: _____ E-Mail Address: _____	Attorney Office Phone Number: _____ Attorney Office Facsimile Number: _____ Attorney Office E-Mail Address: _____
Date of Accident or Injury: _____ Location of Accident or Injury: _____	Liability Claim Number: _____ Adjuster's Name: _____ UM Claim Number: _____
Patient Date of Birth: _____	Attorney Office Contact Person: _____
Patient SSN: _____-_____-_____	Contact Person Phone Number (if different): _____

I, as the Patient, acknowledge:

_____ (initial) **James L. Chappuis, MD ("Dr. Chappuis"), Juilo Petilon, MD ("Dr. Petilon"), Ngan M. Pham, MD ("Dr. Pham"), and SpineCenterAtlanta and its Affiliated Companies ("SCA")[1],** or any combination thereof (collectively the "Providers"), have rendered, are rendering and may continue to render medical services for me, as the Patient named above.

_____ (initial) I, as the Patient, and as the Attorney's client, hereby authorize and direct by my signature below that you as the Attorney handling my matter: (i) to protect to the fullest extent the outstanding bill(s) for services rendered by the Providers to me, as the Patient, related to the Accident/Injury noted above, including without limitation, all fees for medical services (the "Bills"), (ii) to withhold the sums reflected on the Bills form any insurance, settlement, judgment, verdict or other source that may become available to you as my Attorney related to the Accident/Injury, and (iii) to make direct payment of the Bills to any combination of the Providers, immediately upon receipt of funds by you as my Attorney from any such insurance, settlement, judgment, verdict or other sources.

_____ (initial) I, as the Patient, understand and agree that no distribution of monies will be made to me until such time as all of the Providers have been paid in full.

[1] SpineCenterAtlanta and its Affiliated Companies ("SCA"), includes, but is not necessarily limited to, Orthopaedic and Spine Surgery of Atlanta ("OSSA"), Atlanta Orthopaedic Surgery Center ("AOSC"), Integrative Wellness Atlanta ("IWA"), Ortho Stem Cell Atlanta ("OSCA"), SpineCenterConyers ("SCC"), SpineCenterRiverdale ("SCR") and SpineCenterSavannah ("SCS").

_____ (initial) I, as the Patient, understand and agree that I, along with my Attorney, must notify the Providers within five (5) business days of any monetary award by any tribunal, whether or not such monies are at the time of such notice received by me or my Attorney, and that no distribution of any monies whatsoever will be made to me until such time as all of the Providers have been paid in full.

_____ (initial) I, as the Patient, understand and acknowledge that should my Attorney not collect on my behalf, from such settlement, judgment, verdict or other sources, for whatever reason, sufficient funds to pay full all of the Bills, that I, as the Patient, will be responsible for all unpaid Bills, and that failure to pay any remaining balance due may result in the balance due being sent to collections.

_____ (initial) I, as the Patient, direct my Attorney to contact the Providers, or a business representative of the Providers, at the time of my Attorney's receipt of funds on my behalf from any insurance, settlement, judgment, verdict or other sources related to the Accident/Injury and to provide, if requested by the Providers or a business representative of the Providers, a copy of any settlement check, release, settlement agreement, statement of trust or other evidence of the resolution of the matter related to the Accident/Injury.

_____ (initial) I, as the Patient, agree that the above listed instructions are irrevocable and that a copy of this authorization shall have the same force and effect as the original.

_____ (initial) I, as the Patient, agree that if there is a dispute concerning any of the Bills that my Attorney shall hold the disputed amount of money in a law firm trust/IOLTA or similar escrow account until a resolution has been made between me, as the Patient, and the Providers, and that no distributions of any kind shall be made from any disputed money held in such an account, or until such funds are interplead into the registry of the appropriate competent court, or until the proper judge from the appropriate competent court so directs by court order, subject to any rights of appeal from such order.

_____ (initial) I, as the Patient, acknowledge the medical treatment being provided is the result of an injury for which a legal claim is being pursued. I, as the Patient, agree to provide to the medical Providers the name, address, telephone number and email address for the attorney pursuing redress for the injury.

_____ (initial) I, as the Patient, further acknowledge that the payment for the treatment is the responsibility of the patient and is ultimately the patient's sole responsibility irrespective of insurance or payment in this legal matter. I, as the Patient, agree to allow the medical Providers to file a Lien for any outstanding medical bills due as a result of treatment, whether or not payment by insurance has been pursued. To the end, I as the Patient, agree to advise my attorney, or require of my attorney, to collect and pay to the medical Providers all outstanding medical bills.

_____ (initial) I, as the Patient, further acknowledge that to the extent any receivables due the Provider have been assigned by the Provider, that this in no way alters or affects the Patient's obligations under this Letter of Protection, or in any way alters or affects the rights of any assignee.
I, as the Patient, further agree:

_____ (initial) To provide all relevant and necessary information relating to the legal efforts to the medical Providers so they may be able to file appropriate Liens for all outstanding Bills.

_____ (initial) To keep the medical Provider reasonably informed as to the status of any legal efforts and to update any change of address or change in Counsel (attorney). In the event that I, as the Patient, terminate or change legal Counsel upon whom a Lien has been filed by the medical Providers, I will notify the medical Providers of my new Counsel within ten (10) days of engaging new Counsel. Likewise, I, as the Patient, am obligated to place my new Counsel on notice of the Lien(s) with the Providers.

_____ (initial) To acknowledge, honor and insure payment of the Lien(s), either by the current attorney at the time settlement funds shall be distributed, or otherwise by me, with regard to any funds that will be or may be recovered in the legal efforts undertaken on my behalf.

_____ (initial) I, as the Patient, agree the Providers may share my medical information related to the Accident/Injury noted above with my attorney, whose name is provided above, in order to: (a) arrange payment for medical treatment related to the above referenced Accident/Injury, or (b) to bring or substantiate a legal claim related to the above referenced Accident/Injury. I understand that it is my responsibility to inform Providers if I change my attorney and the Providers will not be responsible for sharing information with a previous or former attorney due to my failure to timely notify them that I have changed attorneys.

By signing below all of the undersigned agree to observe and honor the terms and conditions states above.

SpineCenterAtlanta and its Affiliated Companies ("SCA") Representative

_____
Patient Signature

_____
Patient Printed Name

_____
Signature

_____
Printed Name

Attorney and/or "As Agent for the Attorney"

_____
Witness Signature

_____
Witness Printed Name

_____
Signature

_____
Printed Name

_____
Title

_____
Date