MAYO THERAPY ASSOCIATES

CONTRACTUAL GUARANTEE OF PAYMENT FOR HEALTH CARE SERVICES

I hereby authorize and direct you, my attorney, to pay directly to Mayo Therapy Associates such sums as may be due and owing 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, judgment, or verdict as may be necessary to adequately protect said doctor or his/her office. I hereby further consent to a lien being filed on my case by said doctor or his/her office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempted rescission will not be honored by my attorney. I hereby instruct that in the event 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 doctor or his office for all health care bills submitted by him/her for services rendered me. Further, this agreement is made solely for said doctor's additional protection and in consideration of his forbearance on payment. I understand that such 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 [clinic/doctor]'s bill is independent and separate from [clinic/doctor]'s right to file lien to protect its financial interest.**

I specifically request my attorney to acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

_____ _____

Date Signature of Patient

_____ _____

Patient's Driver's License Number Patient's Social Security Number

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

_____ _____

Date Signature of Attorney

Please date, sign, and return one original to Mayo Therapy Associates. Thank you.