Florida Nerve Medicine, L.L.C.
Hildgarde Geisse, M.D.
Neurology

Medical Bills and Medical Reports

Letter of Protection

I, the undersigned, hereby acknowledge that this agreement constitutes a lien against any recovery of proceeds paid by any insurance carrier, or from whatever source, settlement, judgment, or verdict, which may be paid to my attorney, or myself, as a result of the injuries by reason of an accident.

I, hereby authorize my attorney to discuss my case and provide Florida Nerve Medicine, L.L.C. with any information necessary to have payment paid directly to them for such sums as may be due and owing for medical services rendered to me.

I, furthermore, authorize my attorney to withhold such sums from any insurance payments, or from whatever source, settlement, judgement, or verdict, by which I may recover said fee.

I, ______________________________, fully understand that I am directly responsible to Florida Nerve Medicine, L.L.C. for all medical bills incurred for services rendered to me and this agreement does not relieve me of any personal responsibility for said charges.

I, further, understand that this agreement I made solely for the protection of said provider and such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

I understand that this Letter of Protection is irrevocable and shall apply to any cause of action, whether or not I should engage legal counsel, or choose to substitute my attorney, at any future time.

I further acknowledge, and agree, to notify Florida Nerve Medicine, L.L.C in writing if I change or terminate my attorney/client relationship.

X ______________________________ ______________________________

Patient's Signature
Print Name next to signature

Date

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