MATT DOPPS CHIROPRACTIC LLC
555 N. McLean Blvd. Suite 201 Wichita, KS 67203
(316)265-1575

Letter of Protection

Patient: _______________________________

Date of Accident/Injury: __________________

Attorney: ______________________________

Protection of Outstanding Charges

I, ____________________________________(patient) the undersigned patient understand that once money damages are recovered from any person or company after settlement, I hereby direct the attorney to withhold the full amount for the billed charges in this case in connection to the accident. I hereby notify my attorney that I have a lien from the provider Matt Dopps Chiropractic on these benefits or settlement proceeds and this lien is irrevocable. I instruct my attorney to pay for all services rendered directly to the provider, Matt Dopps Chiropractic once the case is settled within 14 days or less. I understand that any settlement, verdict, or judgment proceeds cannot be distributed to me, the patient, without first satisfying this lien.

Should a dispute regarding payment of provider's charges, the patient authorizes and directs attorney to hold in escrow all monies sufficient to satisfy this lien until the dispute can be resolved. The patient acknowledges that it would be a violation of the Attorney's ethical duties to disburse the funds to the patient without first satisfying this lien.

Prior Letter of Protection
This letter of Protection revokes any and all prior letter of protection executed by the undersigned patient and/or Attorney.

I clearly understand that all past, present, and future bills incurred at Matt Dopps Chiropractic are my responsibility for payment and if not paid my case will be considered for collections.

I also, hereby irrevocably agree to have the doctor’s entire bill paid in full from any proceeds of any nature by way of settlement, judgment, or otherwise you may receive. I understand the attorney is to pay the doctor directly prior to disbursing any proceeds to the patient.

I, the patient understand that if the settlement does not cover the doctor’s entire bill, I am still responsible for the remainder.

I do hereby waive any applicable statue of limitations on the collection of my account with this clinic.

I agree not to attempt to negotiate my bill at Matt Dopps Chiropractic and instruct my attorney to not attempt to reduce my bill. I agree to pay in full.

_____________________________________ _____________ ________________________________
Patient Signature Date Parent/Guardian Signature (if minor)

_____________________________________ _____________
Witness Date