ABSOLUTE
PHYSICAL THERAPY
2370 S. Dairy Ashford St., Houston, TX 77077 ♦ Ph: 281-589-8877 ♦ Fax: 281-589-3007

INSTRUCTIONS TO COUNSEL

I, _____, desire to obtain treatment and services from ABSOLUTE PHYSICAL THERAPY. I clearly understand that all bills incurred at Absolute Physical Therapy are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care at this clinic. I also hereby irrevocably agree to have the therapist's entire bill paid from any proceeds of any nature by way of settlement, judgment or enforcement of judgment actions.

You, _____

_____

_____

_____

(Attorney name, address & phone number)

are to honor this lien by paying Absolute Physical Therapy PRIOR to disbursing any proceeds to me NO LATER THAN 30 DAYS after the proceeds of any recovery are received (a 1.5% interest rate will be added to the outstanding balance of any unpaid amount after 30 days).

I also understand that if the settlement does not cover the clinic's entire bill, I am still responsible for the remaining balance.

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

_____

Print Name

_____ _____

Patient Signature Date

_____ _____

Witness / Facility Representative Date