

As the Attorney of record for the above patient, I agree to observe the terms of this agreement and to act in accordance with the agreement between the Clinic and my client by paying _____ directly from the proceeds of any settlement, judgment or recovery that patient is entitled to receive after attorney fees and costs and any valid hospital liens are paid.

Signature of Attorney

Date

Address

Phone

ATTORNEY: Please date, sign and return original to ORTHOPEDIC & TMJ PHYSICAL THERAPY CENTER. Please make a copy for your records. Thank you for your cooperation.