... now I can!
REACTION REHAB™
Physical Therapy

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FEE GUARANTEE AGREEMENT FOR REACTION REHAB, LLC.

Patient's Name: _____ Date of birth: _____

Accident Date: _____ Social Security No.: _____

Treatment Days:

Eval	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20

I, the above-noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the Reaction Rehab, LLC., L.L.C. (hereinafter referred to as "Provider") and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-noted accident date.

Consideration. In consideration of the Physical Therapy treatment provided and time provided to pay for said Physical Therapy treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

Our Fees for treatments. Physical therapy evaluation at $150.00 per hour and Physical therapy treatment at $120.00 per hour.

Protection of Outstanding Charges. The above named Patient hereby agrees that if s/he recovers any money from any person or entity in connection with any legal action related to the above-noted accident date, the Patient shall withhold from those funds, sufficient money pay the full outstanding balance of any bill(s) owed to the Provider for treatment or any work completed in relation to the above-noted accident date. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above-noted treatment. This agreement shall obligate each attorney who represents the above-named patient in any way and recovers any funds related to the above-noted accident date and creates a constructive trust with said attorney. Further, this agreement shall extend pay any outstanding balance for any copies, costs or reports the Provider endures in relation to any legal issue for the above accident date. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the Provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the legal action's proceeds.

Patient Responsibility. It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. Further, the Patient must advise the Provider at reasonable intervals the status of the legal case. It is also the Patient's responsibility to advise the Provider within 5 days of legal matter collecting any funds and to request a bill for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the Provider, as soon as possible, about any funds related to the accident case becoming available to the above-named Patient. Further, if the legal action fails to pay the Provider's outstanding balance(s) fully, then the remaining amounts are to be paid by the Patient. The Provider may, at his/her discretion at any time, bill any third party payer or government payer.

Disputes. If there is a dispute over the Provider's outstanding charges, the Patient agrees to submit the full amount due to the Provider and agrees to bring an action in Florida State Court for recovery of the disputed difference. If the Patient fails to pay the Reaction Rehab, LLC., LLC.'s full outstanding balance, and thereafter Provider brings suit to collect said sums; Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

Approval Required. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient.

The parties agree that no party shall be considered the drafting party to this contract.

_____
Patient's Name (Please Print)

⊗ _____ Date: _____
Patient's Signature: