GOLDEN ORTHOPAEDIC KNEE, HIP, SHOULDER AND FOOT CENTER

13590 Jog Road, Suite 7
Delray Beach, FL 33446
Ph: (561) 637-4200 - Fax (561) 637-3222

9970 Central Park Blvd. S, Suite 300
Boca Raton, Fl 33428
Ph: (561) 488-2200 – Fax (561)488-1064

Marc D. Golden, D.O. Michael Krantzow, D.O. Curtis J. Kephart, M.D. Kevin K. Palmer, D.P.M. Martha J. Solomon, D.P.M.

AUTHORIZATION, ACCEPTANCE, AND ACKNOWLEDGMENT FOR PROTECTION OF PAYMENT

I hereby authorize and instruct my attorney whose signature appears below to pay to the physician members of Golden Orthopaedic Knee and Sports Medicine Center all of the charges for services rendered by the physician and/or staff of said medical center whatsoever or any balance thereof for medical treatment, in hospital or out-patient care, for reports made, deposition given, and time spent as an expert witness in this matter. Said payments shall be made from my monies received by said attorney as a result of any compromise or settlement or by way of collection of any judgment relating to my claim for injuries for which the staff of Golden Orthopaedic Knee and Sports Medicine Center has rendered services.

I hereby authorize Golden Orthopaedic Knee and Sports Medicine Center to furnish, upon request, to my attorney whose signature appears below, copies of medical records pertaining, but necessarily limited to my condition from injuries sustained on or about the ________________ day of _______________, 20_____. It is agreed that nothing herein relieves me of the primary responsibility and obligation of paying my medical bills from Golden Orthopaedic Knee and Sports Medicine Center for all services rendered.

I also understand that if a favorable legal settlement does not occur, I remain personally liable for payment of the total bill for services rendered by Golden Orthopaedic Knee and Sports Medicine Center.

If I have insurance which will cover this bill, I will obtain proper forms and assist the medical office in obtaining payment for the services from these insurance carriers.

In the event of any dispute as to the charge for services rendered, I hereby authorize and direct my attorney to withhold the full sum claimed by Golden Orthopaedic Knee and Sports Medicine Center until such time as the matter is settled by compromise, settlement, judgment, or dismissal. In the event that the medical facility prevails, I shall be responsible for all costs of collection incurred by Golden Orthopaedic Knee and Sports Medicine Center, including a reasonable attorney's fee. Additionally, I hereby agree to waive the defense of the Statute of Limitations. In the event that a claim is filed against me by reason of any unpaid bills, I will not raise the defense of the Statute of Limitations.

I also agree to the terms of the assignment below.

______________________________	______________________________
Witness	Date
______________________________	______________________________
Patient/Parent or Legal Guardian	Patient/Parent or Legal Guardian Signature

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AUTHORIZATION, ACCEPTANCE, AND ACKNOWLEDGMENT FOR PROTECTION OF PAYMENT

I, the undersigned attorney for the patient referred to above, agree to fully comply with the foregoing Authorization, Acceptance, and Acknowledgment for Protection of Payment.
Further, I accept the terms of the above authorization and in consideration of the doctor's agreement to render such medical reports and/or testify and/or be deposed, I shall agree to be personally responsible for any charges relating to medical reports, deposition fees, or expert witness fees. Further, I agree to withhold sufficient funds to pay all sums claimed by Golden Orthopaedic Knee and Sports Medicine Center in full for any services or charges rendered or made until said medical provider consents to the final disposition of the same. I further agree that in the event funds of the patient do not come into my possession then, I will personally be responsible for charges for medical reports, deposition fees, and expert witness fees of the physician members of the referred to medical facility and agree to make full payment within thirty (30) days of disposition of the matter by judgment, settlement, or dismissal. In the event that this case is transferred to another attorney, I acknowledge that Golden Orthopaedic Knee and Sports Medicine Center must be notified in writing, otherwise the obligation of the authorization rest with me.

____
Patient Name

______________________________ ______________________
Attorney Name Date

____
Attorney Signature

______________________________ ______________________
Address Telephone

______________________________ __________ __________
City State Zip Code