

**CONTRACTUAL GUARANTEE OF PAYMENT
FOR HEALTH CARE SERVICES**

I hereby authorize and direct you, my attorney, to pay directly to **EDMONDS MASSAGE CENTER** such sums as may be due and owing in regards to date of loss _____ for health care services for injuries arising from a motor vehicle accident. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said office. I hereby further consent to a lien being filed on my case by said office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or me as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempt to rescind this document will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said office for all health care bills submitted for services rendered to me. Further, this agreement is made solely for said office's additional protection and in consideration of forbearance on payment. I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages. **Also, I understand that my responsibility to pay (the clinic's) bill is independent and separate from (the clinic's) right to file a lien to protect its financial interest under RCW 60.44.**

I specifically request my attorney to acknowledge this letter by signing below and returning it to the clinic's office. I have been advised that if my attorney does not wish to cooperate in protecting the clinic's interest, the clinic will not await payment, but will require me to make payments on a current basis. With balances over 90 days I will pay interest at 1% month (12% annum).

PATIENT SIGNATURE

DATE

PATIENT DRIVERS LICENSE NUMBER

PATIENT'S SOCIAL SECURITY NUMBER

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said office named above.

SIGNATURE OF ATTORNEY

DATE

Please date, sign, and return one original to:
EDMONDS MASSAGE CENTER.
6603 220th Street South West Suite 1-C
Mountlake Terrace, Washington 98043
Thank you,

Kelly Kozelisky
Owner