DR. ROBERT E. FORD, M.D.

308 53RD Avenue East, Suite A
Bradenton, Fl. 34203
Office: 941-752-1916 **Fax: 941-752-2936**

REQUEST FOR LETTER OF PROTECTION

Date:____________________________

To:____
Attorney's Name
____
Attorney's Phone Number
____

Patient Name:__________________________________ Date Of Injury:_________________

I hereby authorize and direct you, my attorney, to pay directly to Dr. Robert E. Ford, MD., such sums as may be due and owing this office for services rendered to me, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault/Liability Benefits, health and accident benefits, worker's compensations benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect this office.

<u>In the event there is no recovery of benefits, I understand that I remain personally responsible for the total amounts due this office for their services rendered.</u>

I authorize Robert E. Ford, MD., to release any information pertinent to my case to my attorney to facilitate collection under this authorization.

I authorize Robert E. Ford, MD., to perform any treatment that they deem necessary, and that I hereby give my consent to such treatment.

Patient Signature:___________________________________ Date:__________________

Attorney Signature:__________________________________ Date:__________________