
**LITIGATION ASSIGNMENT (LETTER OF PROTECTION)**

**PATIENT'S NAME:** _____

**IF MINOR, GUARDIAN OR RESPONSIBLE PARTY:** _____

**DATE OF ACCIDENT/INCIDENT:** _____

**ATTORNEY OF RECORD:** _____

**THIS LITIGATION ASSIGNMENT AND AUTHORIZATION AGREEMENT**, hereinafter referred to as "Agreement" is made this _____ day of _____, 20_____ between **LOWCOUNTRY ORTHOPAEDIC ASSOCIATES/ARCIS HEALTHCARE**, hereinafter referred to as **"Lowcountry/ARCIS"** and the undersigned _____, Patient, if minor, parent or guardian, hereinafter referred to as "Patient" through the attorney of record _____, hereinafter referred to as "Attorney."

**WHEREAS** the Patient through his/her Attorney requests that **Lowcountry/ARCIS** refrain from attempting to collect for current and future medical charges relating to injuries suffered by the Patient in the above referenced accident/incident.

**NOW THEREFORE**, for and in consideration of the above premises and covenants contained herein, all parties heretofore mentioned acknowledge and agree as follows:

This Patient hereby directs his/her Attorney to pay directly to **Lowcountry/ARCIS** all medical charges incurred by the Patient at **Lowcountry/ARCIS** or any of its satellite facilities. The Patient irrevocably assigns this right for **Lowcountry/ARCIS** to collect all related medical charges for which the Patient may be paid under any third-party liability, automobile insurance coverage or any other related insurance. The Patient also acknowledges that there will be no billing or any private or commercial health insurance. The Patient also agrees that if the proceeds from any settlement or verdict resulting from the above accident/incident are not sufficient to satisfy all monies owed to **Lowcountry/ARCIS** and/or any of its satellite facilities **Lowcountry/ARCIS** reserves the right to pursue collection of any outstanding balance. As a condition of this authorization **Lowcountry/ARCIS** agrees to place on hold all collection efforts against Patient until such time as the Patient's claim is adjudicated and all monies resulting from such recovery are paid by the Attorney.

In addition, this Agreement will not cover any pending or denied workers' compensation accidents/incidents.

**THE UNDERSIGNED PATIENT HEREBY AUTHORIZES LOWCOUNTRY/ARCIS TO RELEASE ANY AND ALL OF HIS/HER MEDICAL RECORDS AND BILLING INFORMATION TO HIS/HER ATTORNEY OF RECORD, IN FULL COMPLIANCE WITH ALL APPLICABLE HIPAA RULES.**

**BY SIGNING THIS ASSIGNMENT, THE ATTORNEY OR HIS/HER FIRM ACKNOWLEDGES THAT HIS/HER CLIENT AGREES TO PAY THE MEDICAL PRACTICE OUT OF THE PROCEEDS OF ANY RECOVERY. THE ATTORNEY OR HIS/HER FIRM IS NOT ASSUMING PERSONAL LIABILITY OF THE MEDICAL BILLS OF HIS/HER CLIENT.**

| _____ | _____ | _____ |
|---|---|---|
| Witness | Signature of Patient | Date |

| _____ | _____ | _____ |
|---|---|---|
| Witness | Acknowledgment by Patient's Attorney | Date |