TEXAS BACK CARE
Dr. Carl M. Naehritz III, D.C. & Assoc.
2900 HIGHWAY 121, STE. 120
BEDFORD, TX 76021
(817) 545-1100 FAX (817) 545-1101

NON-RECINDABLE AGREEMENT LETTER

This agreement is between _____ and **Texas Back Care,** and any third-party involved in the accident on_____.

I, _____ do hereby authorize and agree to pay any outstanding balance due on my account at the time of my release from care.

I, _____ agree to allow Texas Back Care/ Carl M. Naehritz III, D.C. to file on my personal injury protection and/or medical pay insurance for services rendered at Texas Back Care. I instruct any monies due from my personal injury protection to be paid directly to my physician. Furthermore, claims shall be paid in accordance with Article 5.06-3, in a timely manner, not to exceed 30 days upon receipt of each claim.

I instruct my attorney to pay in full any outstanding monies due to my physician at the time of settlement with any liability claim that may result from this case. My attorney shall not withhold any portion of the amount due to my doctor under this agreement to offset attorney's fees which my attorney now or hereafter may claim to be owned by me. I instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to the physician/clinic.

I instruct any third-party individual or insurance carrier that may be liable, to pay my physician direct for any outstanding medical bills which are the result of this accident. If payments is not made until time of settlement, I instruct the third party to issue a separate draft to be payable to the physician/clinic for the medical bills.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of my settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment, I understand that the physician/clinic has the right to expect good faith payments on my account and that full payment is being deferred only until such time as a third party settlement occurs. If settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

_____ _____
Patient's Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF AGREEMENT

As the insurance adjuster, or attorney, on this claim, I acknowledge that I have received notice of the patient's agreement and will abide as instructed.

_____ _____
Adjuster/Attorney Signature Date

_____, who stated that he/she had read and understood this Non-Rescindable Agreement Letter, and freely acknowledge that they had agreed to be bound by its terms and conditions,
SUBCRIBED AND SWORN TO on this_____ day of _____, 20____.

_____
Notary Signature Notary Stamp