Be Truly Well

19A Haines Street Newark, DE 19711
(302) 525-4343 *Office* ◆ (302) 266-0450 *Fax*
www.betrulywell.com

DOCTOR OF CHIROPRACTIC

Dr. Jeffrey J. West
Dr. Jodie Kifer

ACUPUNCTURIST

Dongkyu Song, LAC

MASSAGE THERAPISTS

Patricia Mink, LMT
Jessica Strosnider, LMT
Carol Ann Apostolico, LMT

AESTHETICIANS

Kim Madron
Christina Bartkovich
Danuta Kwiatkowska

SERVICES

Chiropractic
Massage & Spa Services
Aesthetician Services
Nutritional Counseling
Vitamins & Supplements
Electric Muscle Stim
Injury Rehabilitation
Cold Laser Therapy
Ion Cleanse Footbath

CHIROPRACTIC HOURS

Monday: 9-1; 3-6
Tuesday: 9-1; 3-6
Wednesday: 9-1; 3-6
Thursday: 9-1 3-6
Friday: 8-1; 3-6
Saturday: 9-11a (chiro)
9-4(Spa)

LETTER OF PROTECTION

Certified Return Receipt #_____ Re:_____
Date of accident:_____ Atty Name:_____
Claim #_____ Firm:_____

I, _____, hereby direct and authorize_____ Esq,, and the law firm of _____to pay all fees for medical services including laboratory bills, medical report fees, appearance fees and other costs to Be Truly Well LLC out of any recovery or settlement of my matter.

I understand that I am fully responsible for all medical bills and administrative charges or other costs incurred on my behalf whether or not there is a recovery through litigation or settlement or if the costs are not covered by insurance. Neither the attorney nor the law firm have any responsibility with regard to those costs and expenses if there is no settlement.

I direct you, as my attorney, to contact Be Truly Well at the time of settlement of my claim to notify them of the recovery and to obtain a statement of my accounts. Bills for services rendered automatically take precedence over any settlement for wages. In addition, I agree that no distribution of monies will be made to me until such time as my undisputed medical bills and costs have been paid.

I hereby agree that the above listed instructions are irrevocable.
A copy of this authorization shall have the same force and effect as the original.

The undersigned attorney for the above patient agrees to observe these terms and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the interests of the service provider. If there is a dispute concerning these costs, the attorney agrees to hold adequate sums of monies in an escrow account until a resolution has been made between the medical service provider and the patient/client.

_____ _____ _____
Patient signature Printed name Date

Attorney instructions: Please sign, date, notarize and return one copy within (5) business days of _____(date):

_____ _____ _____
Attorney signature Printed name Date

Notary for Attorney Signature(required):