Therapy Unlimited, LLC

_24100 Drake Road, Suite B
Farmington, MI 48335-3155
Phone: (248) 442-5011
Fax: (248) 442-5012

_44125 W. Twelve Mile Road
Novi, MI 48377
Phone: (248) 952-4340
Fax: (248) 465-6059

_26751 Southfield Road
Lathrup Village, MI 48076
Phone: (248) 443-5400
Fax: (248) 443-0100

_____
(Patient's Name)

_____
_____, Michigan 48____
(Patient's Address)

_____
(Date)

_____ Insurance Company
_____
_____

ATTN: _____

Re: Insured: _____
Claim No.: _____
Period of Services: _____

Dear _____:

With regard to physical therapy services that have been, or will be, provided by Therapy Unlimited, LLC on my behalf, I hereby request that any and all payments issued by your Company for such services should be issued, made payable to, and sent to Therapy Unlimited, LLC at 24100 Drake Road, Suite B, Farmington, Michigan 48335.

Thank you for your cooperation in this regard.

Very truly yours,

_____

PLEASE BE ADVISED that pursuant to MCL 500.3112, Therapy Unlimited, LLC hereby exercises the right to claim a lien on benefits payable to or for the benefit of the above signed patient, and in accordance with the aforementioned statute, the above signed patient's insurance carrier is directed to issue payments for bills submitted by Therapy Unlimited, LLC directly to this office. In addition, any settlement reached by the above signed patient with any party, claimant or provider other than Therapy Unlimited, LLC is in no way binding upon, and in no way bars any claims asserted by Therapy Unlimited, LLC.

I HEREBY AGREE AND CONSENT TO THE FOREGOING

By:_____
(Attorney for Insured)