

Personal Injury Settlement Agreement
Horizon Health Care Group
P.O. Box 720726
Atlanta, GA 30358
404-252-2520

I, _____, hereby authorize my attorney to directly pay all outstanding medical bills to Horizon Health Care Group. I understand that if my attorney reimburses me with any settlement amounts that I am held solely responsible to pay all medical bills to Horizon Health Care Group.

Failure to pay all remaining medical bills may incur legal and collections action. I understand that this will be avoided assuming my attorney directly reimburses Horizon Health Care Group its full medical bills. I understand that this form will be faxed to my attorney's office.

Signature of Patient/Guardian

Date