

RECEPT HEALTHCARE SERVICES
P.O. Box 171268
Arlington, TX 76003-1268
Phone (817) 572-0009 Fax (817) 572-0221

AGREEMENT TO PROVIDE PHARMACY SERVICES

TO: RECEPT HEALTHCARE SERVICES ("ReCept")

I, (Patient Name) _____ have a claim as a result of injuries which I believe were caused by (Defendant's name) _____ on (date) _____. I appreciate ReCept furnishing physician prescribed medications to me, even though I do not have the funds at this time to pay for said prescription services.

I understand that I (not my attorney, nor any persons who may be responsible for my injury) am directly and fully responsible to pay ReCept for all prescription services incurred by me through ReCept. This Agreement is made in consideration of ReCept providing those prescription services, awaiting payment, and foregoing collection efforts. I understand that ReCept may decide to decline filling any future prescription, and I will remain responsible for all services rendered by ReCept to me as of that date. I further understand that the prices charged for prescriptions by Recept may cost more or less than the prices that I may have paid or could pay at other pharmacies, but that the charges will be reasonable for the services rendered by Recept in arrangements such as the one represented by this Agreement.

I give a lien to Recept on any settlement or jury verdict which I receive as a result of my cause of action. I authorize and direct my attorney to pay directly to ReCept such sum as may be due for services rendered me by ReCept, and to withhold such sum from my portion of any settlement or jury verdict. In the event my portion of the recovery is insufficient to cover all of the protected medical bills in my case, then I will reimburse Recept from my portion of the recovery on a pro-rata basis with any of my other protected medical bills. I further understand, however, that such pro-rata payment will not be considered payment in full by me, and that I remain fully responsible to pay the balance of my bill to you, and that my personal liability is not contingent on any settlement or jury verdict which I may recover.

ASSIGNMENT OF BENEFITS

I hereby authorize Recept Healthcare Services to furnish my attorney with a full report of my medical and pharmacy records in regard to the personal injury claim which I am pursuing.

Date: _____ Client's Signature: _____

As the client's attorney, I acknowledge the above lien, and that my client's signature hereon is genuine. Upon final settlement or jury verdict for this claim, I agree to withhold ReCept's fees from the client's share of any settlement or jury verdict, and forward full payment to ReCept.

It is expressly understood that in the event my lawyer-client relationship is terminated prior to resolution of my client's claim, I will notify you as soon as is practical, and I will continue to use my best efforts to ensure that ReCept's charges remain protected. I will notify the appropriate insurance company(ies) and/or any new attorney that the claims on this matter cannot be finalized without payment of ReCept's fees in accordance with this Agreement.

Additionally, I recognize that ReCept charges a nominal, reasonable fee for records and affidavits.

Attorney Name: _____

Date: _____ Attorney Signature: _____