Pure Wellness
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

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699 S. Carter Rd
Suite 5
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PHYSICIANS

Eric Marks, D.C.
Joelle Renaud, D.C., ICCSP, CKTP
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Kyle Clayton, D.C.
Kelly Brown, D.C., L.Ac., MSA
Ying Ko, L.Ac., EMP

SERVICES

Chiropractic
Acupuncture
Massage Therapy
Functional Medicine

NEWARK HOURS

Monday: 8-1; 3-6:30
Tuesday: 8-1; 3-6
Wednesday: 8-1; 3-6:30
Thursday: 8-1; 3-6
Friday: 8-1
Saturday: 8-2

SMYRNA HOURS

Monday: 12-5
Tuesday: 9-1; 3-7
Wednesday: 9-1; 3-7
Thursday: 9-1; 3-7
Friday: 9-12
Saturday: By Appt Only

WILMINGTON HOURS

Monday: 12-6
Thursday: 8-1

LETTER OF PROTECTION

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 our of any recovery or settlement of my matter.

I understand that I am fully responsible for all medical bills, witness fees 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 responsible with regard to those costs and expenses.

I direct you, as my attorney, to contact Pure Wellness at the time of settlement of my claim to notify them of the recovery and to obtain a statement of my accounts. 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 signature	Printed name	Date