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Medical Provider's Lien

Patient Name: ______________________________ **DOB:** _____________ **DOI:** _________

Attorney: ___________________________________ **Insurance Carrier:** ___________________

I do hereby authorize _________________________________ to furnish you, my attorney/insurance carrier, with a full report of my case history, examination, diagnosis, treatment, prognosis, etc. in regard to the accident in which I sustained injury.

I hereby give a lien on my case to Complete Body P.T. against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself directly, as a result of the injuries for which I have been treated or injuries in connection therewith. I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing said provider for medical services rendered to me by reason of this accident any bills that are due the provider's office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said provider..

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by said provider for service rendered me and that this agreement is made solely for said provider's additional protection and in consideration of the provider awaiting payment. I further understand that my personal responsibility to provide such payment is not contingent on the success of any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said provider of any change or addition of attorney/insurance carrier used by me in connection with this accident, and I instruct my attorney/insurance carrier to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney/insurance carrier.

Please acknowledge this letter by signing below and returning to the provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment but may declare the entire balance due and payable.

Patient Signature: _____________________________________ Date: ________________________

Attorney/Insurance Carrier

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to adequately protect the above referenced provider.

Attorney/Authorized Agent Signature: ____ Date: ________

Please sign, date, and return one copy to Complete Body PT to verify receipt. Retain one copy for your records.