Accident Lien

To Attorney or Agent: **From Physician or Clinic:**

I do hereby authorize the above Doctor to furnish you, my attorney, insurance carrier, or agent, with a full report on his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident or illness, which occurred on or about _____.

I do hereby authorize and direct you, my attorney or agent, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me, and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor.

I fully understand that full payment to said doctor is not contingent on any settlement, judgement or verdict. In consideration of medical fees not having been paid when services were rendered (as is customary), I myself, my attorney or agent, promise not to ask or expect said physician to discount his medical fees for the services that were rendered; in the event that such settlement, judgement, or verdict, is insufficient or lower than expected.

I hereby further give a first lien (that supercedes all other previous liens) on my case, to said doctor, against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, my agent, other creditors, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

If within one year from said date of which accident or illness was said to occur, said doctor has not been paid in full for all monies owed; then I agree to interest levied, compounded at 1.25% per month on all unpaid medical fees, to begin 90 days after the day medical services were first rendered. I do hereby authorize and direct you, my attorney or agent, to withhold such sums of money from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named. I do hereby direct you, my attorney or agent, to contact said doctor to verify his receipt of full payment for medical services before I get paid.

This instrument is an irrevocable assignment of monies from the undersigned to said doctor, in the amounts designated here, and such assignment may not be revoked or terminated by the undersigned or anyone else without the prior written consent of said doctor. I agree to pay all court cost and attorney fees incurred in the collection, or attempted collection, of this debt.

Initial: _____

The undersigned, being attorney or agent of record for the above patient, does hereby agree to observe all the terms of the above; and to contact said doctor to verify his final statement of medical service fees; and to withhold such sums of money from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named. Furthermore, if said attorney or agent, fails to furnish payment to said doctor in ten days from the date the check, draft, or order of settlement is received; then said attorney or agent does hereby agree to 1) interest levied, compounded at 1.25% per month on all unpaid medical fees, to begin 90 days after the day medical services were first rendered, and 2) the payment of all court cost and attorney fees incurred in the collection, or attempted collection, of this debt.

_____ _____

Patient Signature **Date**

_____ _____

Attorney or Agent Signature* **Date**

*** IMPORTANT**
Please date, sign and return one copy to doctor's office at once.
Attorney or Agent: Reply envelope attached. Keep one copy for your records.

Initial: _____