MEDICAL LIEN FOR POSITIOINS CHIROPRACTIC LLC

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For good and valuable consideration received, I (Patient’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, being the undersigned, authorize and direct my Insurance Company to pay directly to Dr. Christopher Pounds D.C. and Positions Chiropractic LLC any sums as may be due and owing this chiropractic office for services rendered me, both by reason of accident, or illness and/or by reason of any other bills that are due this chiropractic office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and/or accident benefits, workers’ compensation benefits, or any other insurance benefits or reimbursement whatsoever for which you may be obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said chiropractic office. In further consideration of the above-indicated treatment, I hereby give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlements, judgment, or verdict, which may be owed me as a result of the injuries or illness for which I have been treated by said office. This contract to act as an assignment of my rights and benefits to the extent of the office's charges for services provided herein.

I, the undersigned, further hereby authorize and direct my attorney when settlement or judgment is reached, to pay in full the chiropractic bills rendered for all treatment and services as a result of the injuries or illness for which I have been treated by said office and any other amounts which I may owe said office at that time. In further consideration of the treatment rendered herein, I do hereby authorize the chiropractic office to furnish you, the above indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

*I UNDERSTAND THAT BY SIGNING THIS DOCUMENT I AM AUTHORIZING RELEASE OF REPORTS AND INFORMATION TO THE ABOUT-INDICATED PARTY, WHICH COULD INCLUDE THE RESPONSIBLE PARTY'S INSURANCE COMPANY.*

Furthermore, I authorize the chiropractic office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and medical authorization. In the event any insurance company is obligated to make payments to me upon the charges made by this office for the service rendered and refuses to make such payments, I hereby assign and transfer to this office any and all causes of action, claims, whether in law or equity, that I might have or that might exist in my favor against such company, and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this chiropractic office to compromise, settle or otherwise resolve any claim or cause of action at its sole discretion herein as it relates to amounts owed this doctor or office.

I understand that I am directly and fully responsible to said office for all medical bills submitted by them for services rendered me and this agreement is made solely for said office's additional protection. I further understand that such payments are not contingent on any settlement, judgment or verdict by which I may eventually recover said fees. Said medical payments are due on demand by the office. I further understand and agree that said assignment, lien and authorization do not constitute any consideration for the office to await payment and it may demand payments from me immediately upon rendering services at its option. This agreement is irrevocable and is binding upon the heirs, executors and legal representatives of the undersigned.

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Printed Name of Patient Signature of Patient Date

Or Parent/Guardian (if a minor) or Parent/Guardian (if a minor)

**Patient Name: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTORNEY ACKNOWLEDGEMENT OF ASSIGNMENT, LIEN, AND AUTHORIZATION AND RELEASE OF MEDICAL RECORDS AND INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, attorney for the above-indicated patient hereby acknowledge receipt of the above assignment and lien and agree to protect said chiropractic office pursuant to above- indicated terms and make payment payable directly to POSITIONS CHIROPRACTIC LLC.

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Printed Name of Attorney Signature of Attorney Date

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Attorney Address Attorney Phone Number

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Please date, sign and return to the address listed below.