Arcadia Radiology
MEDICAL GROUP

612 West Duarte Road, Suite 101, Arcadia, California 91007
Tel (626) 445-4850 • Fax (626) 821-3460 • www.ArcadiaRadiology.com

MEDICAL LIEN

Please print:

Attorney's Name: _____ **Patient's Name:** _____

Address: _____ **Address:** _____

City/State/Zip: _____ **City/State/Zip:** _____

Phone #: _____ **Phone #:** _____

I do hereby authorize the above medical provider to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing him for medical services rendered to me both by reason of this incident and by reason of another settlement, judgment or verdict as may be necessary to adequately protect said provider. I hereby further give a lien on my case to said provider against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

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

I agree that if I change attorneys, that this agreement will remain enforce and effect and that I will notify any subsequent attorney of this lien and notify you the name, address, telephone number of my new attorney.

I agree to waive the statute of limitation for the services you provided to me pursuant to Code of Civil Procedure Section 360.5.

Should any party fail to abide by the terms of this agreement and suit be filed to enforce any term or condition, the prevailing party shall be entitled to reasonable attorney fees.

This agreement shall be inuring to the benefit and be binding upon the heirs, successors or assigns of the parties. This agreement shall be deemed made and accepted at Arcadia Radiology Medical Groups office located in Arcadia, California. Venue for any action on this lien shall lie exclusively in the County of Los Angeles.

Patient's Signature: **Date:**

<u>This agreement cannot be changed, altered or modified without written consent of the medical provider.</u>

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said medical provider above named prior to the payment of any part of such settlement, judgment, award, or verdict to the Patient named above.

I agree to notify you if I discontinue the patient in pursuit of their claim. I agree to provide you status of their claim upon your written request.

Attorney's Signature: **Date:**

***Attorney: Please sign, date and return the original to the medical providers' office at once. Keep one copy for your records.**