NEUROLOGY PARTNERS, P.A.
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DOCTOR'S LIEN

_____ _____ _____
(Attorney Name) (Attorney Phone) (Attorney Fax)

_____ _____/_____/_____ Date of Accident _____/_____/_____
(Patient Name) (Patient D.O.B.)

I hereby give lien to Neurology Partners, P.A. on any settlement, claim, judgement, or verdict as a result of said accident/illness, and authorize and direct you, my attorney to contact Neurology Partners, P.A. at the time of settlement to determine the amount due and owed to Neurology Partners, P.A. I direct my attorney to hold the complete outstanding balance in Trust for the benefit of the Neurology Partners, P.A. This agreement is binding and irrevocable without the written consent of Neurology Partners. I authorize and direct my attorney to pay directly to said physician such sums as may be due and owing him for services rendered me, and to withhold such sums from settlement, claim, judgement, or verdict as may be necessary to protect said physician adequately. These amounts will be disbursed to said physician at time of settlement. Should the attorney/client relationship terminate for any reason prior to the conclusion of my treatment, **THE UNDERSIGNED ATTORNEY AGREES TO NOTIFY ME WITHIN SEVEN (7) DAYS OF SUCH TERMINATION.**

I fully understand that I am directly and fully responsible to said physician for all medical bills submitted by him for services rendered me, and that this agreement is made solely for said physician's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover said fee. I, the undersigned patient, hereby acknowledge that I have read and understand the above information. I have been given the opportunity to have any of my questions answered to my satisfaction.

Patient's Signature _____ Date _____/_____/_____

Witness Signature _____ Date _____/_____/_____

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 protect adequately said above named doctor. I agree to promptly notify Neurology Partners upon the receipt of any and all settlement funds relating to the referenced accident.

Attorney Authorized Signature _____ Date _____/_____/_____

NOTICE: The signature of the above attorney is only to acknowledge receipt of the above lien, but in no way is the above attorney personally responsible for any bills on behalf of the above client.

Please note we will bill your medical insurance as a courtesy once your auto insurance benefits exhaust. However, if your medical insurance fails to pay any services provided the bills will be your responsibility.

Sign, date, and mail/fax to physician's office at once. Keep one copy for your records.