Doctor's Lien and Instructions to Counsel

I, the undersigned, understand that all past, present and future bills incurred at the Doctor and Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor and Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injuries/illnesses, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/injuries/illnesses and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/injuries/illnesses.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore, in consideration for the below named Doctor/Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable stature of limitations on the collection of my account until I notify the Doctor/Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three months thereafter.

Doctor/Clinic Name and Address:

Pacific Spine & Sports
3 Corporate Park, Ste 168
Irvine, CA 92606

_____
Patient Name (Print)

_____
Patient Signature

_____
Date

Instructions to Counsel

I do hereby irrevocably instruct you, my Attorney (named below), to pay Doctor/Clinic (named above) in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctor/Clinic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

_____ _____
Firm Name Patient Signature

_____ _____
Attorney Name (Print) Date

Attorney's Acceptance of Lien

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to counsel and lien and agree to honor the same.

_____ _____
Attorney Signature Date