Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do hereby authorize **DOCTORS NAME** to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved. I also acknowledge that such Chiropractor or his/her representative(s) may provide further consideration in exchange for this lien/assignment; including deposition testimony, trial testimony, and requested report(s).

I hereby authorize and direct you, my current and any successor attorney(s); together with any responsible insurance company, to pay directly to **DOCTORS NAME** such total sums as are currently due and may become due and owing him/her in the future for all Chiropractic treatment and related services rendered me or my office both by reason of this accident that are due to his/her office and to further withhold such total sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said office for such total sums. I hereby further give a lien or assignment of my potential benefits on my pending/prospective case to said office against any and all insurance benefits, referenced below, and proceeds of my settlement, judgment, court order or verdict which may be paid to you, my attorney, and/or myself as a result of the injuries or illness for which I have been or will be treated from a Chiropractic scope of care perspective in connection with such accident.

I fully understand that I am directly and fully responsible for bills submitted by him/her for services rendered to me and that this agreement is made for said treaters additional protection and in consideration of his/her awaiting payment and other services provided by him, as referenced above. I further understand that such payment is not contingent on any settlement, judgment, court order or verdict by which I may eventually recover said fee and that my doctor may take appropriate and timely action to enforce payment against me for all such outstanding bills. I further acknowledge and agree that this executed lien/assignment shall be binding upon any subsequent and/or additional attorney(s) regardless of whether this written document is expressly acknowledged by such attorney. I also acknowledge and agree that the attorney shall not have the authority to obtain any or all of the insurance Med-Pay, as it is strictly used for reasonable and necessary medical services, not for an attorney fee.

This agreement shall be binding upon the patient’s heirs, successors, personal representatives or assigns.

Dated: \_\_\_\_\_\_\_\_\_\_ Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (or Parent/Legal Guardian if Patient is Minor)

The undersigned, being attorney of record for the above patient, does hereby acknowledge receipt of this notice and hereby agrees to honor and comply with all the terms of the above agreement and agrees to protect adequately and/or otherwise withhold such sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further acknowledge that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney’s fees and costs. This agreement shall be binding upon any successor, agent, representative, employee or substituted and/or added attorney(s) of the patient with the same force and effect.

Dated: \_\_\_\_\_\_\_\_\_\_\_\_ Attorney Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_