BLUEBEAM RADIOLOGY

MEDICAL LIEN

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PATIENT

I hereby authorize the above medical facility to furnish my Attorney with a full report of the examination, diagnosis, treatment, and prognosis of myself in regards to the accident in which I was involved.

I hereby authorize and direct my Attorney to pay directly to said doctors such sums as may be due and owed the provider for professional services and rendered to me, both by reason of accident and by reason of any other bills that are due to the provider's offices and to withhold such sums from any settlement, judgment, or verdicts as may be necessary and adequate to protect said provider. I hereby further direct my Attorney to pay in full any medical bills owed to the provider.

I fully understand that I am DIRECTLY AND FULLY responsible to said provider for all professional bills submitted for services rendered to me and that the above-stated is made solely for said provider's additional protection and in consideration of his waiting payment. I further acknowledge that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient Name

Phone

Address

Date of Injury

Date of Service

City

Patient Signature

State

Postal Code

Email

Today's Date

ATTORNEY

The undersigned being Attorney of record for the above patient hereby agrees to observe all the terms of the above and agrees to withhold all sums from any settlement, judgment or verdict as may be necessary and adequate to protect the provider. Attorney agrees to update provider on a consistent basis regarding the status of the claim.

Attorney Office

Phone

Address

Fax

City

Attorney Signature

State

Postal Code

Attorney Email

Today's Date