CORE CHIROPRACTIC

DR. STEVEN FINNELL / DR. AARON LYON
149 IRON POINT ROAD - FOLSOM, CA 95630
Phone: (916) 989-1014 Fax: (916) 989-1461

- NOTICE OF DOCTOR'S LIEN -

Patient Name: _____ **Date of loss:** _____

Attorney Name: _____

_____

_____

I hereby authorize CORE CHIROPRACTIC/Steven Finnell, D.C., to hereby furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct my attorney, to pay directly to **CORE CHIROPRACTIC / Steven Finnell D.C.**, such sums as may be due and owing for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to the provider and to withhold such sums from any settlement of judgment as is necessary to adequately protect the provider.

I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you my attorney.

I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider 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.

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

_____ _____

PRINT PATIENT NAME **DATE**

_____ _____

SIGNATURE OF PATIENT **SIGNATURE OF PARENT/GUARDIAN**

ACKNOWLEDGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead 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, **CORE CHIROPRACTIC / Steven Finnell D.C.**

_____ _____

ATTORNEY'S SIGNATURE **DATE**

NOTE TO ATTORNEY *PLEASE SIGN AND RETURN ONE COPY TO THE PROVIDERS OFFICE; KEEP A COPY FOR YOUR RECORDS*

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-PERSONAL LIEN-

I do hereby agree to pay directly to **Finnell Chiropractic/CORE Chiropractic** such sums as may be due and owing the doctor for medical services rendered me both by reason of this accident and by reason of any other bills that are due to **Finnell Chiropractic/CORE Chiropractic.** I hereby further give a lien on my case to the said doctor against any and all proceeds of my settlement, judgement or verdict which may be paid to 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 the said doctor for all medical bills submitted by **Finnell Chiropractic/CORE Chiropractic** for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover the said fee.

This lien covers my balance at **Finnell Chiropractic/CORE Chiropractic** only and is to be paid in full either before or within 10 business days of receiving my settlement from any involved insurance companies. The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the said doctor named below.

_____ _____

Date Patient and/or Guardian's Printed Name

_____

Patient or Guardian's Signature

_____ _____

Date Doctor's Printed Name

_____

Doctor's Signature