NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize _____ to furnish you, my attorney, with full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved. I hereby authorize and direct you, my attorney, to pay directly to the above-named doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or 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 above-named doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I eventually recover said fee.

I agree to promptly notify the above-named doctor of any change or addition or attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the above-named doctor will not await payment but may declare the entire balance due and payable.

Date _____ Patient Signature _____

The undersigned, being attorney of record 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 and fully compensate the above-named doctor for all services rendered to said patient. Attorney further agrees, in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

Date _____ Attorney Signature _____

Attorney Name _____

Address _____

City, State, Zip _____

Phone _____

Please date, sign and return the original copy to the above-named doctor. Also keep one copy for your records.

Date _____ Doctor Signature _____

Doctor Name _____

Address _____

City, State, Zip _____