Doctor:
ACCELERATED URGENT CARE
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RE: MEDICAL REPORTS AND DOCTOR' LIENS

Attorney:
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Patient Name: ____________________________

DOB: ___________________________

I, Patient/Client, hereby authorize and direct you, my attorney, to pay directly to Accelerated Urgent Care (hereinafter referred to as "Doctor"), at the address listed above, such sums as may be due and owing Doctor (including any medical services performed by licensed physicians and medical-related staff such as nurse practitioners) for medical service provided to me both by reason of this accident or injury (and any follow-up care) and by reason of any other bills that are owed by me to Accelerated Urgent Care, and to withhold such sums received from any personal health insurance coverage, personal medical payment coverage, award, settlement, judgment or verdict as may be necessary to adequately protect Doctor. I hereby give a lien on my case to Doctor against all proceeds received by way of my own insurance coverage or by way of settlement, award, judgment or verdict which may be paid to you, my attorney, or others as the result of the injuries/illnesses for which I have been treated.

I hereby instruct my attorney that in the event another attorney is "substituted-in" for this matter, that the new attorney shall be provided written notice of this lien from the "substituted-out" attorney, with a copy of this lien attached to said notice. I hereby agree that in the event a new attorney is "substituted-in," I shall be deemed to have instructed the new attorney to honor this lien as if it were signed by him/her, and to further execute and protect the lien as the new attorney of record.

I hereby agree to instruct my attorney to provide Doctor with name(s), address(es), telephone number(s) and claim number(s) of all insurance carriers involved in my case or claim. I further agree that in that event I move my residence prior to the final disposition of my case; I shall notify Doctor in writing as to my new address and telephone number. I further agree that I shall instruct my attorney to respond in writing to any request made by Doctor as to the status of my case. I further understand that if neither I nor my attorney cooperate in protecting Doctor's interest, Doctor is permitted to declare the entire balance, owed to him, immediately due and payable.

I fully understand that I am directly and fully responsible to Doctor for all medical and related bills submitted by Doctor for services rendered me and that this agreement is made as consideration to Doctor awaiting payment. I further understand that my obligation to Doctor for full payment is not contingent on any settlement, award, judgment or verdict. If I have received any payment for my claims and have not paid Doctor for his lien, I hold such payment in trust for Doctor.

I further agree that if an appointment is canceled or rescheduled by me within 24 hours of appointment, that a charge of $100 for follow-up visit and $200 for initial visit will be charged to me. I further agree that this Lien authorization constitutes the final agreement between us and that any modifications hereto would have to be in writing, signed by the patient, doctor and attorney of record. In addition, I further agree that if Doctor needs to pursue legal action to enforce the terms of this agreement, attorney fees and costs shall be awarded to the prevailing party.

I also hereby authorize Accelerated Urgent Care, address as indicated above, to furnish my attorney with

an itemized billing statement, copies of my records and a full report of examination, diagnosis, treatment, prognosis, etc., of myself regarding the accident/injury/illness in which I was involved.

If Accelerated Urgent Care is asked to provide expert testimony or prepare a report as it relates to expert testimony, I understand and agree to pay for their expert fees in addition to any medical services billed.

I REPRESENT TO ACCELERATED URGENT CARE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO HAVE MY LEGAL COUNSEL REVIEW THIS MEDICAL LIEN AGREEMENT AND HAVE EITHER DONE SO OR HEREBY WAIVE MY RIGHT TO DO SO. I HAVE COMPLETELY READ EACH OF THE TERMS OF THIS MEDICAL LIEN AGREEMENT. I EXECUTE (SIGN) THIS MEDICAL LIEN AGREEMENT VOLUNTARILY, WITH FULL KNOWLEDGE AND
UNDERSTANDING OF EACH OF ITS TERMS AND CONDITIONS, AND I HEREBY AGREE TO BE BOUND BY EACH OF THE TERMS AND CONDITIONS OF THIS LIEN AGREEMENT

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Dated	Patient Name	Signature

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above agreement and agrees to withhold such sums received by way of the patient's own insurance coverage or by way of a settlement, award, judgment, or verdict which may be paid to either the patient or you, either jointly and severally, to adequately protect Doctor. I further agree to provide Doctor with the name(s), address(es), telephone number(s) and claim number(s) of all insurance carriers involved in the patient's case. I further agree that I shall respond in writing to any written request made by Doctor as to the status of the patient's case, on the condition that said request is not made more than every four months. In addition, I further agree that in the event that Doctor needs to pursue legal action to enforce the terms of this agreement, attorney fees and costs shall be awarded to the prevailing party.

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Dated	Attorney Name	Signature

ATTORNEY: PLEASE DATE, SIGN AND RETURN ONE COPY OF THIS LIEN IMMEDIATELY.
PLEASE KEEP ONE OF RECORD