



Office Use Only
MRN _____

MEDICAL LIEN

ATTORNEY Name: _____
Address: _____ City: _____
State: ___ Zip: _____ Phone #: (___) ___-____ Fax #: (___) ___-____
PATIENT Last Name: _____ First Name: _____
Social Security Number ___/___/____, Date of Birth ___/___/____
Date(s) of Accident(s): ___/___/____, ___/___/____, ___/___/____, ___/___/____

I do hereby authorize the above facility to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., with regard to the accident in which I was involved.

I hereby authorize and irrevocably direct you, my attorney, to pay directly to said facility such sums as may be due and owing to them for medical services rendered me by reason of this accident that are due this office: and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said facility. I hereby further irrevocably give a lien on my case to said facility against any and all proceeds of 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.

Facility may revoke this lien in the event attorney and/or patient fails to provide facility with reasonable periodic status reports or patient's claim as requested by facility. In the event said lien is revoked, payment will be due for services rendered by facility immediately.

I fully understand that I am directly and fully responsible to facility for all medical bills submitted for services rendered, and that this agreement is made solely for facilities additional protection and in consideration of 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.

This contract is binding upon me, whether or not signed by my attorney. In the event I change or substitute attorneys at any time, or from time to time, prior to payment in full of all medical billings and other charges, if any due facility, this irrevocable direction and lien shall be binding thereon upon their being furnished a copy hereof. A photocopy of this lien will be considered as valid as the original.

PATIENT'S SIGNATURE: _____ DATE: ___/___/____

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 facility named above. Counsel further agrees to notify facility in writing at such time as this patient's case is surrendered to the patient/client or is transferred to a new attorney.

ATTORNEY'S NAME: _____ DATE: ___/___/____
Please Print

ATTORNEY'S SIGNATURE: _____

ATTORNEY: PLEASE sign and fax back to Orange County Diagnostics at (949) 462-3777.

NOTE: Medical report and bill will not be forwarded until properly signed lien has been returned to this office.

Table with 3 columns: Laguna Woods office (24301 Paseo De Valencia Suite 100), Ladera Ranch office (600 Corporate Drive, Suite 110), and Mission Viejo office (27725 Santa Margarita Parkway, #101). Each column lists address, phone, and fax numbers.