

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize _____ Chiropractic Center to furnish to you, my attorney, with a full report of the doctor's 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 said 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 as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injury for which I have been treated or injuries in connection otherwise.

I fully understand that I am directly and fully responsible to said doctor for full medical bills submitted by him for service rendered to 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 may eventually recover said fee.

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

Dated: _____

Patient's 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 said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: _____

Attorney's Signature

Please date, sign and return one copy to the doctor's office. Also keep one copy for your records.

Dr. Maureen (Molly) Keefe
Back to Health Family Chiropractic
St. Albans, VT 05478
(802) 527-BACK(2225)
(802) 527-2013(fax)