ENCINO OPEN MRI

17323 Ventura Blvd Suite 101 Encino, CA 91316
Tel: 818 986-4786 Fax: 818 986-4798

PATIENT – ATTORNEY MEDICAL LIEN AGREEMENT

I do hereby authorize **ENCINO OPEN MRI, INC.** to furnish you, my attorney, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay directly to **ENCINO OPEN MRI, INC.,** such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to **ENCINO OPEN MRI, INC.** for all medical bills submitted by said practice for services rendered to me and that this agreement is made solely for said practice's additional protection and in consideration of the practice awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict, insurance company's determination, with the exception of a recognized workers compensation case, by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting ENCINO OEN MRI, INC., the practice will not await payment and may declare the entire balance due and payable.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of California.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date of Injury: _____

Home Address, City, State, Zip_____

_____

_____

OFFICE USE ONLY

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

_____ _____
Attorney's Name Date

_____
Attorney's Signature

State bar No._____ Address_____
Phone Number_____ Fax Number_____