SCOTT DAVIS
CHIROPRACTIC

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DOCTOR'S LIEN

Patient's Name: _____ Date of Incident: _____

I do hereby authorize Scott Davis Chiropractic/Scott Davis, D.C., to furnish my attorney named below with a full report of my examination, diagnosis, treatment, prognosis, etc., regarding the incident in which I was recently injured.

I further authorize and direct my attorney to pay directly to Scott Davis Chiropractic/Scott Davis, D.C., such sums as may be due and owing for medical services rendered to me both by reason of this incident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctors.

I hereby further give a lien on my case to Scott Davis Chiropractic/Scott Davis, D.C., against any and all proceeds of my settlement, judgment or verdict which may be recovered or paid as the result of the injuries for which I have been treated. I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any recovery made by me. I hereby agree to waive the defense of Statute of Limitations as it pertains to any claim filed against me beyond three years (or other statutory) after services were rendered. I agree to promptly notify said doctor of any change or addition of 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 by signing this document, the doctor will not await payment but may declare the entire balance due and payable at the time of service.

Patient's Signature _____ Date: _____

Patient's Printed Name _____

The undersigned attorney or insurance company agrees:
1. To comply with the above "authorization and assignment";
2. To withhold and pay from my proceeds from settlement, collection of judgment, PIP, med-pay or other insurance proceeds, the amount of the doctor's charges, after contacting the doctor's office for a current balance; 3. Advise within ten days of the doctor's requests, the status of the above referenced claim;
4. To notify the doctor of any changes in the status of the claim which may preclude payment of the doctor's charges;
5. To notify any attorney who may assume the representation of the patient of assignment.

Attorney's Signature: _____ Date: _____

Attorney's Printed Name: _____

Attorney's Contact Information: _____

Mailing Address: _____

Phone: _____ Fax: _____ Email: _____