Pow-HER Chiropractic
600 Jefferson Plaza, Suite 350
Rockville, Maryland, 20850
Phone: 301-279-9009 Fax: 301-279-9008

Patient: _____
Print

Lawyer: _____
Print

RE: PATIENT RECORDS AND DOCTOR'S LIEN

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my, accident/illness which occurred/began on:_____

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said accident/il1ness, and authorize and direct you, my attorney/insurance carrier to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said provider adequately.

I fully understanding that I am directly and fully responsible to said provider for all bills submitted by he/she for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his /her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said funds.

I further agree to be fully responsible for reasonable attorney's fees and cost that have accrued due to the pursuance of payment of my account. Also, that in the event of non- compliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Dated: _____ Patient's Signature: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Dated: _____ Attorney's Signature: _____