Medical Lien For Medical Services

(MRI)

Doctors Resources Company
1500 W. El Camino Avenue #304
Sacramento, CA 95833
(916) 922-6747
(916) 922-6767 (Fax)

Patient Name: ___________________________ Facility: **University Medical Imaging**
Date of Birth: _______________

I, _____________________________________, have, or will, receive medical imaging services from University Medical Imaging (hereinafter referred to as õMedical Facilityö). I do not have the funds to pay for these services, but I need this medical treatment as a result of an injury I sustained. In consideration of Medical Facility providing these medical services I grant Medical Facility a medical lien to be paid directly from the proceeds of any personal injury judgment, settlement, arbitration award or any other funds received as a result of my injuries arising out of my injury. If I receive no personal injury judgment, settlement, arbitration award I acknowledge that I still owe Medical Facility the full and reasonable value of the medical treatment I have received or that I will receive.

I acknowledge that Medical Facility has the right to collect this lien from me in the future. I authorize Medical Facility to release all of my current or future medical and billing records in its possession, or which come into its possession, to any representative of my current or future attorneyøs office. I authorize DOCTORS RESOURCES COMPANY, LLC to discuss any aspect of my medical condition, treatment and/or billing matters with my attorney and I grant my attorney (my current attorney or any attorney I hire in the future) the authorization to discuss any aspect of my medical condition, treatment and/or billing matters with any representative of the Medical Facility.

I direct my attorney to pay the full value of all money owed to Medical Facility before my attorney disburses ANY of my personal injury judgment, settlement, and arbitration award (this is not intended to prevent my counsel from recovering the attorney fees before distributing the settlement funds). In the event of a dispute arising out of paying the Medical Facility I direct my attorney to hold the full value of the services rendered by Medical Facility in my attorneyøs client trust account until this dispute is resolved.

I direct my attorney to sign this õMedical Lien for Medical Servicesö within 10 days of it being signed by me and I direct my attorney to update the Medical Facility of ANY changes to my case which affects the outcome of my case.

This lien is binding on any subsequent attorney I hire. I acknowledge that no term or condition of this lien may be altered IN ANY WAY without the written consent of an authorized representative of the Medical Facility. The Medical Facility and I both agree that the statute of limitations relating to any dispute over payment, or non-payment, of this debt shall not begin to run until personal injury judgment, settlement, arbitration award has been disbursed to me.

In the event of a dispute which arises out of this lien the prevailing party in litigation shall be entitled to the all attorney fees and all costs (including expert witness fees incurred by the prevailing party). This lien agreement can be signed in counterparts and it has the same force and affect as if it were signed by all parties simultaneously. A faxed copy and/or a photocopy of this document has the same force and effect as an original document and a faxed copy and/or a photocopy of this document can be used in place of, and instead of, the original in any future legal proceeding.

DATE: ____________________ PATIENT SIGNATURE: ________________________________

If patient is under the age of 18:

DATE: ____________________ PARENT/GUARDIAN SIGNATURE: _______________________

I acknowledge that I have reviewed all the terms and conditions of this lien. I acknowledge that I am the Patientøs current attorney and that in the event I am no longer the attorney for the patient I will forward this lien to the new attorney for the patient and I will personally notify the Medical Facility of the new attorneyøs name, address and telephone number within 5 days of learning this information.

DATE: _____________________ ATTORNEY SIGNATURE: ______________________________

FIRM NAME: ____