Patient's Full Name: _____

Date of Birth: _____ **SSN:** _____ **Date of Accident:** _____

Attorney's Name *(& Law Firm's if applicable)*: _____

Attorney's Mailing Address: _____

Attorney's Tel: _____ **Attorney's Fax:** _____

Attorney's Email: _____ **Paralegal/Other Contact:** _____

MEDICAL REPORTS / DOCTOR'S LIEN / ASSIGNMENT OF BENEFITS

I do hereby authorize Premier Orthopaedics & Sports Medicine, here after referred to as POSM, to furnish my attorney with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved. I also acknowledge that POSM or his/her representative(s) may provide further consideration in exchange for this lien/assignment; including deposition testimony, trial testimony, and requested report(s).

I hereby authorize and direct you, my current and any successor attorney(s); together with any responsible insurance company, to pay directly to POSM such total sums as may be due and owing for all medical care, treatments, products, and related services rendered to or for me both by reason of this accident pending/prospective case and by reason of any other bills that are due to POSM and to withhold such sums from any and all insurance benefits, settlement, judgment, court order or verdict, as may be necessary to adequately protect and fully compensate POSM for such total sums.

I further give a lien or assignment of my potential benefits on my pending/prospective case to POSM against said insurance benefits, settlement, judgment, court order or verdict which may be paid to you, my attorney, and/or myself as a result of the injuries or illness for which I have been or will be treated from a medical scope of care perspective in connection with such accident. POSM does not accept percentages on outstanding bill for treatment/care rendered. POSM will be paid in full or 100% of any outstanding bill after treatment is completed. This lien extends to my proceeds of any settlement and should not affect my attorney's right to recover expense and attorney fees.

I fully understand that I am directly and fully responsible to POSM for all medical bills submitted by them for services rendered me and that this agreement is made solely for POSM's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, court order or verdict by which I may eventually recover said fee and that POSM may take appropriate and timely action to enforce payment against me for all such outstanding medical bills.

I agree to promptly notify POSM prior to any change or addition of attorney(s) used by me in connection with this accident, and I instruct my present attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I further acknowledge and agree that this executed lien/assignment shall be binding upon any subsequent and/or additional attorney(s) regardless of whether this written document is expressly acknowledged by such attorney.

I request that my attorney(s) acknowledge this lien/assignment by signing below and returning to POSM. The undersigned agrees that a copy of this lien may be forwarded to third parties responsible for payment to the patient and that such third parties can act directly in protecting such lien/assignment. Such insurance benefits shall include any coverage(s) provided to the patient(s) for liability, disability, medical payments coverage, no-fault, health and accident, workers compensation, and any other applicable benefits. Such insurers are directed and authorized to withhold and reimburse to POSM such amount as necessary to satisfy the total sum owed by me for medical care, products, and services.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Date	**Patient's Signature** ***(or Parent/ Legal Guardian if Patient is Minor)***	**Patient's Printed Name** ***(or Parent/ Legal Guardian if Patient is Minor)***

The undersigned, being the attorney of record for the above patient, does hereby acknowledge receipt of this notice and hereby agrees to honor and comply with all the terms of the above agreement and agrees to protect adequately and/or otherwise withhold such sums from any insurance benefits, settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate POSM. A photocopy of this form shall be considered as valid as the original.

Date	**Attorney's Signature**	**Attorney's Printed Name**

Please date, sign, and return a copy to POSM, while ensuring to also keep a copy for your records.

PREMIER ORTHOPAEDICS & SPORTS MEDICINE
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