Spine Sync Medical Lien Agreement

Date of Injury Incident:_____

Patient Information:

Name: _____

Address:_____

Phone number: _____Email:_____

Law office Information:

Attorney's name: _____

Office name: _____

Address: _____

Phone number: _____Email:_____

Case#: _____

Provider Information:

Provider's name: Forester Dean, DC of Spine Sync at 2300 Artesia Blvd #B, Redondo Beach, CA 90278
Phone number: 310-663-8602 FAX: 949-695-4970 (receives only)
Email: spinesync@gmail.com
Provider's website referencing rates: www.spinesync.org/downloads

1. I, _____ ("Patient"), desire medical and other treatments and therapy from Dr. Forester Dean, DBA Spine Sync, and including all appropriate services provided by physicians and specialists ("Care") that provide services for, at, or on behalf of Spine Sync, (collectively "Provider"), for injuries sustained in the above-referenced personal injury case ("Incident"). I have retained the above-referenced counsel ("Attorney") to seek compensation ("Claim") for my injuries arising from the Incident. I understand that Provider, at my request and as an accommodation to me, has agreed to treat me on a lien basis pursuant to this Medical Lien Agreement. The agreed billing rate is Provider's posted Insurance EOB rate ("Charges"). I understand that a lien is considered to be a legal binding agreement, and I promise to pay the charges in full to Provider at the end of my case ("Settlement") within 14 days by personal check or cash in US dollars ("Monies").

2. I hereby grant to Provider a lien upon, and direct my Attorney to pay Provider from, any sums awarded to me or my personal representative, by judgment, award, court ruling, verdict or pursuant to a settlement, mediation or compromise, in the amount and to the extent of Provider's billed charges, in full and without negotiation for a lesser sum. I further understand that I am directly and fully responsible to pay for the care provided to me by Provider whether or not I receive a financial award from my claim, and that this Medical Lien Agreement is made solely for additional protection of Provider and in consideration of Provider awaiting payment, and within 14 days of discharge by Provider whether or not the claim has settled, or if the course of care has been completed.

3. I hereby authorize and direct Provider to release medical records and reports ("Documentation") to my Attorney for distribution to other parties involved in my claim, including other medical providers, insurance adjusters, claims administrators, and the like. I understand that it is not the responsibility of Provider to release my claim

documentation directly to any party other than to my Attorney, which courtesy will not be unreasonably withheld. All communications will be made via secure email, hardcopies delivered by hand or postal mail.

4. I fully understand that I am directly responsible to the Provider to pay for all care provided to me as demonstrated in the charges. If the need to bill any private insurance arises, I understand that it will be my responsibility to submit any billings to my private health insurance for any payments or reimbursement, if applicable. I further understand that Provider will not bill any private health insurance carrier(s) as it is my sole responsibility to do so if and where applicable. The lowest acceptable payment rates for services is determined by using the 60-percentile rate calculated by Fair Health Consumer (www.fairhealthconsumer.org) on the date of settlement.

5. My Attorney will notify Provider in writing of any objection or issue concerning Provider's care or charges prior to the start of treatment or no later than five (5) days following receipt of any bill or statement. My Attorney will keep Provider updated on the status of the claim, promptly communicate the date of filing of the claim and case number, the setting or moving of trial/arbitration/mediation, any change in Patient's representation or if co-counsel is brought in to try the claim (in which case co-counsel shall also be bound by this Medical Lien Agreement), and the disposition of the Litigation, including the amount of any settlement, judgment or other award. Best efforts shall be used, and time is of the essence.

6. I understand and agree that if any provision of this Medical Lien Agreement is not followed by me or my Attorney, and without meaningful and urgent correction, the Provider may declare a breach, and I thereupon agree to pay the full balance owed to Provider within five (5) days, and if I fail to pay Provider, it is within the Provider's right to file a lawsuit against me for all charges, and I will be obligated to pay Provider for any attorneys' fees incurred enforcing this Medical Lien Agreement, including a $250 Administration fee payable to Spine Sync, court filing fees, and interest equal to 12% assessed monthly on all unpaid balances of the claim.

7. This Lien Agreement may not be altered, modified, revoked, or compromised in any way without approval of Provider, and without demand to compromise, and shall remain in force and effect at all times until all monies due to Provider have been paid in full to satisfy the claim.

8. This document may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute but one and the same Agreement. The parties agree that this agreement may be electronically signed, and that any electronic signature(s) appearing on this agreement shall be deemed the same as handwritten signatures for purposes of validity, enforceability and admissibility and is binding as an original.

9. I represent to Provider that I have been given the opportunity to have my legal counsel review this Medical Lien Agreement and have either done so or hereby waive my right to do so. I have read each of the terms of this Medical Lien Agreement, Parts 1-9. I execute this medical lien agreement voluntarily, with full knowledge and understanding of each of its terms and conditions, and I hereby agree to be bound by each of the terms and conditions of this lien agreement. This Medical Lein Agreement becomes binding with the signatures of all parties.

Patient Signature:_____Date:_____

Attorney Signature:_____ Date:_____

Provider Signature:_____ Date:_____