PALMER CHIROPRACTIC CLINIC

Diane Sherwood-Palmer, D.C
10767 16th AVE SW
Seattle, WA 98146

NOTICE OF DOCTOR'S LIEN

ATTORNEY:_____

ADDRESS:_____

CITY:_____STATE:_____

I do hereby authorize the above named doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc; of myself in regards to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay to said doctor such sums as may be due and owing him/her for medical service rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission to said doctor will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for services rendered me and that this agreement is made solely for said doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney fees, and/or court cost will be added to the total amount due.

Please acknowledge this letter by signing below and returning it to the doctor's office. 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 may declare the entire balance due and payable.

Dated:_____Patients Name (Printed):_____

Date of Accident:_____Patient's Signature:_____

Witness:_____Address:_____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney of record for the above patient does herby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, out of monies, otherwise not payable to the patient, as may be necessary to adequately protect the said doctor above named. Any settlement of this claim without honoring this assignment/lien will cause the patient to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs. This agreement is non revocable.

Date:_____Attorney's Signature:_____

Attorney

1. Please date, sign and return one copy to the above named doctor's office at once.
2. Keep one copy in client's file.