TOTAL BODY WELLNESS PRO

7748 Hampton Place, Suite B, Loganville, GA 30052 Phone:678-821-2810 Fax: 678-894-0342

ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES

Attorney/Insurance: _____ **Patient**: _____

_____ **Patient #:** _____ **D/A** _____

_____ **SSN #:** _____ **DOB**:_____

FOR VALUE RECEIVED, I hereby assign unto ***Total Body Wellness Pro*** and/or its Physician to the extent of my bill for health care services and all claims which I may have against any other party who's NEGLIGENCE may have caused my injuries on the above captioned date or who may be legally responsible for my injuries and health care costs.

I further assign to *Total Body Wellness Pro* a irrevocable lien in the amount of my outstanding medical bill for health care services rendered for an accident which occurred on the above captioned date against the proceeds of any insurance policy, health care plan, or any claim which I may have against any other party whose negligence may have caused my injuries. I fully understand & agree not to rescind mv directive to mva attornev to honor this lien.

I hereby authorize payment be made directly to the *Total Body Wellness Pro* or its Assignee. I hereby appoint ***Total Body Wellness Pro*** irrevocable, to ask, demand, sue for, collect, endorse, sign, and receive any such insurance or other benefits or claims against other parties for my injuries. Although ***Total Body Wellness Pro*** shall be granted such powers contain herein, ***Total Body Wellness Pro*** is not obligated or compelled to exercise such powers but may do so at ***Total Body Wellness Pro*** discretion. ***Total Body Wellness Pro*** is further empowered to provide any and all information and documents pertaining to my policies including a copy of such policy and any information or supporting documentation concerning or touching upon the handling, calculation, procession, or payment of any claim.

I fully understand & agree not to rescind my directive to my attorney to honor this lien. Failure of my Attorney to sign this document does not release him/her of the fiduciary responsibility of ensuring that my outstanding medical bill is paid unto ***Total Body Wellness Pro***.

BY SIGNING YOUR NAME BELOW YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENTED TO TOTAL BODY WELLNESS PRO AND ITS DOCTORS FOR EVALUATION AND/OR TREATMENT OF A HEALTH RELATED CONDITION OCCURING ON THE ABOVE DATE AND FOR NO OTHER PURPOSE.
BY SIGNING THIS DOCUMENT, PATENT FULLY UNDERSTANDS ALL PROVISIONS SET FORTH IN THIS AGREEMENT. A PHOTOCOPY OR FAX COPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.
In the event that any provision of this agreement is determined to be invalid or unenforceable, all other provisions of this agreement shall remain enforceable.

IN WITNESS WHEREOF, the Agreement has been entered the day and year set forth below.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date

To Be Complete By your Attorney:

The undersigned Attorney of Record for the above-named Patient, hereby agrees to observe all terms stated herein and agrees to withhold such sum payable to *Total Body Wellness Pro* from any settlement, judgment or verdict as may be necessary to adequately protect *Total Body Wellness Pro*. Attorney is expressly directed to hold in Attorney's Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as my be required to adequately protect and pay *Total Body Wellness Pro* for services rendered on Patients behalf by *Total Body Wellness Pro*. Attorney is further directed to pay from Attorney's Client Trust Account to *Total Body Wellness Pro* that amount which is due and owing to *Total Body Wellness Pro* for those medical services, examinations, treatments and reports which *Total Body Wellness Pro* has prepared on Patient's behalf. Attorney further agrees that in the event Patient secures other counsel in connection with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall inform such new counsel of the Agreement, and secure new counsel's consent there to. Failure of Plaintiff Attorney to sign and return this document to *Total Body Wellness Pro* does not release him/her of the fiduciary responsibility of ensuring that the above patient's outstanding medical bill for treatment rendered for injuries rendered for injuries sustained on the above captioned date is paid unto *Total Body Wellness Pro* out of the proceeds of his/her case per your client's written request.

Attorney's Signature: _____ Date: _____

Attorney: Please sign and mail or fax to *Total Body Wellness Pro* at the address/ fax # below:
7748 Hampton Place, Suite B, Loganville, GA 30052
Telephone: 678-821-2810 Fax: 678-894-0342