[redacted]

ASSIGNMENT AND AUTHORIZATION /ATTORNEY LIEN

Form should be completed and signed by both the patient and attorney and returned to the address above

I [redacted], do hereby irrevocably assign to [redacted] (hereinafter "[redacted]"), and authorize and direct attorney(s) listed below to pay to [redacted] from the proceeds of any recovery in my claim or case to extent of all of [redacted] charges for services rendered to include but not limited to: charges for health care services provided, charges for reports, preparation for testimony, deposition and court testimony as an experts witness. These charges shall be paid whether proceeds of monies are received from med-pay, no fault or any other insurance policy. Furthermore I do hereby specifically agree to payment of above said proceeds directly to [redacted] and do hereby authorize and direct any additional future new or other succeeding attorney(s) of mine or of my representatives or successors to do the same. I hereby also agree to waive the defense of the statute of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services are rendered. I understand and agree that this does not relieve me of my personal responsibility to pay for such services and that payment IS NOT contingent upon recovery in my claim/case. [redacted] agrees not to send account(s) to a collection agency while my claim is actively pursued by my attorney as documented by updates provided to hospital in accordance with terms herein. If no recovery is made, I will personally be responsible for the balance of my account. I also, hereby authorize [redacted] to furnish my attorney named below with copies of medical reports (if requested) in reference to services provided by [redacted]. A photocopy of this agreement shall be binding as the original.

[redacted] [redacted] [redacted]

Patient (Print Name) *Patient's Signature* *Date*

[redacted] [redacted]

Account # (S)

I the undersigned attorney for the patient referred to above, hereby agree to comply fully with the foregoing "Assignment and Authorization:" and will with hold and pay from any proceeds from settlement, collection of judgement, med-pay or other insurance proceeds the amount of provider's charge after contacting the provider's office for current balance. The undersigned also agrees to advise [redacted] in writing within 10 days of their request of information regarding the status of the claim of the patient, and to notify [redacted] immediately of any change in the status of this case which may preclude payment of these medical charges by me for any reason. I further agree to require any attorney to whom the undersigned refers this case, within or outside the firm, to honor this assignment as a condition of referral. I further agree to furnish home and work address information about the patient or family in aid in collection of bills.

Name of attorney: [redacted] *Attorney Signature:* _____ *Date:* _____

Firm Name: [redacted] *Phone #:* [redacted]

Address: [redacted]

Attention: Please sign form and return copy to

[redacted]