Notice of Lien on Settlement Proceeds & Assignment of Right to Proceeds of Claim

Facility: LifeSport Chiropractic LLC

Patient Name: _____

Date of Accident/Injury:_____

Location of Injury: _____County_____ State

"Patient" shall include any child or dependent for whom "Patient" is legally responsible.

In consideration of the Facility/Doctor furnishing services to me, and because I do not have sufficient insurance or funds available to pay in advance for care, I hereby grant a lien to Facility/Doctor against any and all settlement proceeds resulting from and arising out of the negligence of a third party which occurred on the date of accident stated above, causing injuries and the need for reasonable and necessary health care, which Facility/Doctor, shall provide. Along with the lien granted above, I assign to Facility/Doctor the right to receive settlement funds, based upon said lien, in the amount of the remaining balance owed by Patient to Facility/Doctor at the time any such settlement occurs. This lien and assignment shall apply to settlements with any liability insurance company of a third party, and to any Uninsured/Underinsured Motorist insurance claim which I make against an insurance company providing benefits to Patient.

_____ Because services are to be rendered in reliance upon this agreement, I agree this agreement shall be irrevocable after being signed by both parties. I agree and understand that I shall remain personally responsible for payment to Facility/Doctor for all bills for services provided to patient. This agreement is made for the mutual benefit of both patient and Facility/Doctor, and in consideration of Facility/Doctor awaiting payment until a settlement shall occur

before requiring patient to make payment.

_____I understand that services provided for auto-related injuries require higher documentation standards by the rendering physician and will not be eligible for submission to my health insurance policy.

_____ I understand and authorize that any unpaid services at 90 days post discharge may be charged to my credit card unless such charges have been disputed in writing 30 days from date of service. I also understand that my attorney needs to attempt to settle my case in a timely manner.

_____ I further understand that I am personally responsible for payment to Facility/Doctor regardless of the outcome of my case. Patient's obligation to make payment is not contingent upon any settlement or judgment by which patient may eventually recover. I agree that should I not receive any settlement, judgment or verdict within 3 months from date of discharge, Facility/Doctor may bill me directly requiring payment of all amounts owed. I recognize my healthcare providers are not party to my suit against the at-fault party and waive the Common Fund Doctrine in regards to settlement proceedings.

Venue: Disputes regarding this agreement shall be adjudicated in County,

Patient Signature_____

Print Name of Signer _____

Date_____

Visa/MC #_____ Exp. _____

Doctor's Signature _____

Print Name of Signer _____Date_____