

DOCTOR'S LIEN

To whom it may concern:

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Dr. Robert Hall such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness, and by reasons of any other bills that are due this office and to withhold such sums from any disability benefits, medical payments, benefits, health and accident benefits, worker's compensation benefits or any other insurance benefits, obligated to reimburse me from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Dr. Robert Hall. I hereby further give to said office, against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of Dr. Hall's services provided.

In the event my insurance company, obligated to make payment to me upon the charges made by this office for their services, refused to make such payments, upon demand of action that might exist in my favor against such company.

I understand that I remain personally responsible for the total amount due to Dr. Robert Hall for his services. I further understand and agree that this Assignment, await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize Dr. Robert Hall to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____