

**LOCUST GROVE CLINIC, P.C.
ASSIGNMENT, LIEN AND AUTHORIZATION**

➤ *If this is not a car accident, only fill in your Name and Insurance Co. Name*

Patient Name _____

Claim or File #: _____

Address _____

Date of Loss: _____

City & State _____

Insured's Name _____

Date of Birth _____

Insurance Company Name and Policy # _____

To Whom It May Concern:

I hereby authorize and direct you (my insurance company, liability insurance adjuster, and/or attorney) to pay directly to: Peter J. Tully and/or Elizabeth C. Tully d/b/a The Locust Grove Clinic, P.C. such as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all cause of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorized this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due to the office for their services. I further understand and agree that this assignment, Lien and Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including reasonable attorney's fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, Lien and Authorization. I agree that the above mentioned office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill and that my attorney provide the above named doctor a copy of the settlement and disbursement sheet or file, including settlement amount, expenses and disbursements prior to settlement. 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. A photocopy of this agreement shall be considered as effective and valid as the original.

Date _____ Signed: _____

Date _____ Witness: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect said doctor above named.

Date _____ Signed: _____

Note to attorney: If you prefer please send your acknowledgement of this lien on your letterhead.