orange county
PAIN & REHAB

ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES

l. Certification, Authorization and Release in Accordance with HIPAA. Patient and Attorney of Record ("Attorney") certify that the information provided herein is correct and complete. Patient understands that, in accordance with the Health Information Portability and Privacy Act of 1996 ("HIPAA'), Patient's medical information relating to this personal injury case may be shared to manage and expedite Patient's medical treatment. Patient authorizes Maryam Rahimi, D.O. to secure, release, and disclose such medical treatment information with companies and individuals as deemed necessary, and further agrees that examinations, diagnoses, medical treatments, films and reports can be shared with necessary parties involved in Patient's case. Attorney acknowledges that Attorney has obtained a Release of Medical Information from Patient for purposes of communications regarding Patient's medical information and that Maryam Rahimi, D.O. is covered by said Release.

ll. Assignment and/or Lien for Medical Services. Patient and Attorney understand that the medical services, supplies and/or treatment Patient is receiving as part of the ongoing personal injury claim may be billed as a lien as may be authorized by applicable state law and practice. Patient hereby grants to Physician a lien on proceeds of any settlement and/or judgment in Patient's pending legal action. Patient acknowledges that Physician has assigned its right to payment and to such lien to Maryam Rahimi, D.O. and that Maryam Rahimi, D.O. has the exclusive right to collect all amounts due for services by Physician. Patient does not have the financial resources to pay the charges at this time and patient does not have insurance coverage to cover such medical services, whereby such insurance coverage would include, but is not limited to, health insurance, Workers' Compensation, government or other medical insurance coverage. Patient and Attorney acknowledge that the amount subject to this lien constitutes the ordinary and customary charges by Maryam Rahimi, D.O. for such medical services, supplies and/or treatment. Patient and Attorney understand that they are responsible for informing Maryam Rahimi, D.O. of any change in financial situation as it relates to medical care and coverage. A photocopy and/or fax copy of the executed lien shall have the same force and effect as the original.

lll. Patient Information.

Patient Name: _____ Date of Injury: _____ Physician: Maryam Rahimi D.O.

Attorney Name: _____ Telephone: _____ Fax: _____

Attorney Address: _____ City: _____ Zip: _____

(This assignment and Lien covers the foregoing case relating to the subject injury or claim.)

lV. Payment Agreement. Patient Authorizes and directs Attorney to pay Maryam Rahimi, D.O. as assignee Physician, directly for any billings arising out of the medical services, treatment and care, that have been or may be rendered to patient by Maryam Rahimi, D.O. Physician as a result of this incident and reason of any other bills which Patient may owe Maryam Rahimi, D.O. Physician. Patient understands that Patient remains personally responsible for Maryam Rahimi, D.O. Physician billings and that this obligation is not contingent upon Patient's receiving any settlement for Patient's claim. Patient will notify Maryam Rahimi, D.O. of any payment received by Patient for medical services from an insurance company or other source, and Patient will instruct his/her attorney to likewise notify Maryam Rahimi, D.O. All payments will be forwarded to Maryam Rahimi, D.O. Patient understands that the legal settlement may pay all; part or none of Patient's account and that Patient is responsible for complete payment of account. Patient understands that Patient is financially responsible for any amount unpaid by this assignment of proceeds or lien, as may be authorized by applicable state law and practice. By signing this document, Patient fully understands all provisions set for in this Agreement.

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 Maryam Rahimi, D.O. Physician from any settlement, judgment or verdict as may be necessary to adequately protect Maryam Rahimi, D.O. 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 may be required to adequately protect and pay for such services by Maryam Rahimi, D.O. Physician. Attorney is further directed to pay from Attorney's Client Trust Account to Maryam Rahimi, D.O. for those medical services, examinations, treatments and reports which Maryam Rahimi, D.O. Physician has had 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.

Patient's Signature: _____ Date: _____

Attorney's Signature: _____ Date: _____

8201 Newman Ave Ste 302 Huntington Beach, CA 92647
Telephone: (949) 610-1042 Fax: (949) 610-1049

3300 West Coast Hwy Ste C Newport Beach, CA 92663
Telephone: (949) 610-1042 Fax: (949) 610-1049

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Huntington Beach
8201 Newman Ave Suite 302
Huntington Beach, CA 92647

Newport Beach
3300 W. Coast Hwy #C
Newport Beach, CA 92663

PERSONAL INJURY HISTORY

Personal Information: **Today's Date**:_____

Full Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Insurance Information: If using Insurance other than your Health Insurance. (i.e. Homeowners, Vehicle, etc)

Insured's Name:_____ _____ _____
(First) (Middle) (Last)

Insurance Company:_____ ID#:_____ Group #:_____

Attorney Information:

Have you retained and Attorney: { }Yes / { }No (If **Yes** Please answer the following Information:)

Your Attorney's Name:_____

Your Attorney's Address:_____ City:_____ State:_____ Zip:_____

Your Attorney's Phone #:_____ Fax #: _____ email:_____

Injury Information:

Date of Injury:_____ Time of Injury:_____ am/pm Type of Injury:_____

What City did Injury happen:_____ Cross Streets:_____

Where Police on Scene:{ }Yes/{ } No * Where Paramedics on scene:{ }Yes/{ } No * Where you taken by Ambulance { }Yes/{ } No

How did the accident happen:

_____

_____

_____

_____

Where you the passenger or driver? _____ Where you wearing a seatbelt:_____

Name of vehicle Owner:_____ Was the vehicle totaled?:_____

Had You or the Driver been drinking or taking Drugs?:_____

If **Yes** (how much and when):_____

Other people in the accident?:_____ Were they injured?:_____

If **Yes** the extent of their injuries:_____

Please list any and all Parties that are at Fault or Played a Role in the happening of this accident, People, Road Conditions, Obstructed Views, Etc:_____

_____

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Have you been involved in an Auto Accident in the Past?:_____ If **Yes** when?:_____

Have you ever been injured before?:_____

If Yes type of injury and date(s) of occurrence(s):

1.)_____ 2.)_____

3.)_____ 4.)_____

5.)_____ 6.)_____

Have you ever been hospitalized before?:_____ If so when and why?:_____

1.)_____ 2.)_____

3.)_____ 4.)_____

Have you ever made any type of claim (Work Comp, Auto, Social Security Disability or Other Claim) for the injuries sustained in this accident?:_____ If Yes (state the type of Claim, Injury Involved and Date Claim Made:

1.)_____ 2.)_____

3.)_____ 4.)_____

Lis All Hospitals, Med-Centers, Doctors, Physical Therapist (etc. seen for your injuries and dates:

1.)_____ 2.)_____

3.)_____ 4.)_____

Lis any Restrictions and the Doctor who Authorized them:

1a.)_____ 1b.)_____

2a.)_____ 2b.)_____

Dates of Upcoming Medical Appointments, Name of Doctor and Reason for Visit:

1.)_____ 2.)_____

3.)_____ 4.)_____

Current Condition:

_____

_____

_____

_____

Do you work?: { }Yes/{ }No Type of Work?:_____ Name of Employer:_____

Any time lost from work?:_____ If so what date(s)?: From:_____ To:_____

Describe Injury:

_____

_____

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Are your Symptoms: { } Improving { } Getting Worse { } Same { } Other_____

Name of any other Doctors Consulted since your accident:

1.)_____ 2.)_____

3.)_____ 4.)_____

List the treatments you have received:

1.)_____ 2.)_____

3.)_____ 4.)_____

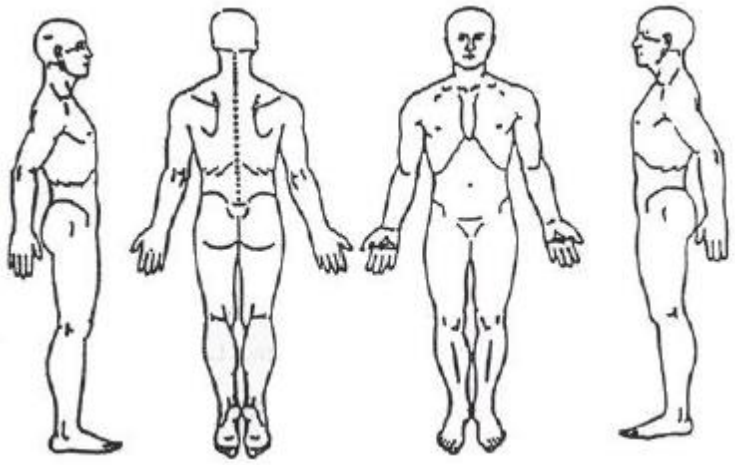
List the types of Diagnostic Testing that has been performed for this problem:

{ } X-Rays { } CT Scan { } MRI Scan { } Other_____

Please use the Legend Symbols below to Accurately mark the areas in which you feel these sensations:

Pain= PPP Sharp= SSS Burning= BBB

Numbness= NNN Tingling= TTT Dull= DDD



(Right) **(Back)** **(Front)** **(Left)**

Pain Rating:

On a scale of 0-10, Rate Your Pain: (Please Circle one of the Numbers that Best Describes Your Pain)