Joseph E. Pierson MD
6333 Wilshire Blvd, Suite 411, Los Angeles, CA 90048
Office: 323 944 0949, Fax: 323-782-0388
Email: authdepartment@alliedhealthsolutions.com

DOCTOR'S LIEN

ATTORNEY/INSURANCE COMPANY:

_____

_____

PATIENT NAME:_____

DATE OF LOSS/ACCIDENT:_____

I do hereby authorize _____JOSEPH E. PIERSON_____M.D. to furnish the above referenced entity, with a full report of this examination, diagnosis, treatment, prognosis, etc of myself in regard to the accident in which I was involved.

I hereby authorize and direct the above referenced entity to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, above referenced entity or myself as the result of the treatment or injuries for which I have been treated or injuries in connection therewith. I further understand that if my medical bill is recovered by my attorney or above referenced entity, regardless of payment in full and /or partially due to the necessary settlement reductions, the above named doctor will allow a deduction by my attorney or above referenced entity for his legal fees or any fees, on a pro-rate basis, equal to the percentage of attorney fees or any other fees charged to me by him, my attorney or above referenced entity.

I agree never to rescind this document and that a rescission will not be honored by my attorney or above referenced entity. I hereby instruct that in the event another attorney or entity is substituted in this matter, the new attorney or entity honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I furthermore understand that such payment is not contingent on my settlement, judgment, or verdict by which I may eventually recover said fees.

PATIENT SIGNATURE:_____**DATE**_____

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

ATTORNEY/INSURANCE REP

SIGNATURE:_____**DATE**_____

Dear attorney or insurance representative, please date, sign and return this correspondence within the next ten days to the address above.

Allied Health Solutions Medical Group

6333 Wilshire Blvd. Suite 411 • Los Angeles, CA 90048

Phone (323) 944-0949 • Fax (323) 782-0388

Patient Information Report

CATEGORY: _____ FILE NO.: _____

DATE OF INJURY: _____ TIME OF ACCIDENT: _____ a.m. / p.m.

LOCATION: _____

CITY: _____ WEATHER: _____

POLICE REPORT: YES _____ NO _____ REPORT NUMBER: _____

AGENCY & LOCATION: _____

AMBULANCE: YES _____ NO _____ HOSPITAL: _____

OTHER REPORTS (TO WHOM & DATE): _____

INJURED PARTY:

NAME: _____ DOB: _____

ANY OTHER NAMES USED (MAIDEN NAME): _____

NAME OF GUARDIAN TO MINOR: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME: (_____)_____ Work: (_____)_____ MISC.:(_____)_____

D/L or ID NO.: _____ S.S. NO.: _____

LANGUAGE SPOKEN: _____ LEGAL STATUS: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

CHILDREN:

NAME:	DATE OF BIRTH:	DEPENDENT: YES or NO

EMERGENCY CONTACT: _____

ADDRESS: _____

PHONE: (_____)_____ RELATIONSHIP: _____

Patient Signature _____ **Date** _____

EMPLOYED: YES _____ NO _____

EMPLOYER: _____

ADDRESS: _____

PHONE: (_____)_____OCCUPATION _____

DATE OF EMPLOYMENT: _____ SALARY: _____

HEALTH INS.: YES _____ NO _____

NAME OF COMPANY: _____

ADDRESS: _____

PHONE: (_____)_____ GROUP NO.: _____

INJURIES (DESCRIBE IN DETAIL): _____

_____

_____

MEDICAL FACILITIES: _____

_____

_____

PRIOR ACCIDENT(S): YES _____ NO _____ DATE: _____

DESCRIBE ACCIDENT: _____

INJURIES FROM PRIOR ACCIDENT(S): _____

_____

_____

GENERAL DESCRIPTION OF HOW THE ACCIDENT OCCURRED:

_____

_____

_____

_____

_____

_____

_____

_____

_____

CLIENT'S VEHICLE AND INSURANCE INFORMATION:

YEAR: _____ MAKE: _____ MODEL: _____

COLOR: _____ LICENSE PLATE : _____ DRIVEABLE: YES / NO

LOCATION OF VEHICLE: _____

REGISTERED OWNER: _____ PHONE: (_____) _____

ADDRESS: _____

LEGAL OWNER (IF DIFFERENT): _____

INSURANCE CO: _____

PHONE: (_____) _____ POLICY #: _____

ADJUSTER: _____

ADDRESS: _____

PHONE: (_____) _____ CLAIM # _____

POLICY LIMITS:

LIABILITY	COMP./COLL	DEDUCTIBLE	UM / UIM	MED PAY

1 Where were you coming from? _____

2. Where were you going? _____

3. What direction where you traveling? _____ On what street: _____

4. What direction was the defendant? _____ On what street: _____

5. How many lanes were there? _____ What lane were you in? _____ Defendant? _____

6. What speed were you traveling? _____ Defendant? _____

7. Did defendant have passengers? _____ How many? _____

PASSENGER'S INFORMATION:

NAME: _____ DOB: _____

ANY OTHER NAMES USED (MAIDEN NAME): _____

NAME OF GUARDIAN TO MINOR: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME: (____)_____ Work: (____)_____ MISC.:(____)_____

D/L or ID NO.:_____ S.S. NO.:_____

LANGUAGE SPOKEN:_____ LEGAL STATUS: _____

EMERGENCY CONTACT: _____

ADDRESS: _____

PHONE: (____)_____ RELATIONSHIP: _____

EMPLOYED: YES _____ NO _____

EMPLOYER: _____

ADDRESS: _____

PHONE: (____)_____ OCCUPATION _____

DATE OF EMPLOYMENT: _____ SALARY: _____

HEALTH INS.: YES _____ NO _____

NAME OF COMPANY: _____

ADDRESS: _____

PHONE: (____)_____ GROUP NO.: _____

INJURIES (DESCRIBE IN DETAIL): _____

_____

_____

MEDICAL FACILITIES: _____

_____

_____

PRIOR ACCIDENT(S): YES _____ NO _____ DATE: _____

DESCRIBE ACCIDENT: _____

INJURIES FROM PRIOR ACCIDENT(S): _____

_____

DEFENDANT'S INFORMATION:

NAME: _____ D.O.B.: _____

ADDRESS: _____

HOME: (_____) _____ WORK: (_____) _____ MISC.: (_____) _____

D/L or ID NO.: _____ S.S. NO.: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: (_____) _____ OCCUPATION: _____

STATEMENTS MADE AT SCENE: _____

_____

_____

_____

DEFENDANT'S VEHICLE AND INSURANCE INFORMATION:

YEAR: _____ MAKE: _____ MODEL: _____

COLOR: _____ LICENSE PLATE : _____ DRIVEABLE: YES / NO

LOCATION OF VEHICLE: _____

REGISTERED OWNER: _____ PHONE: (_____) _____

ADDRESS: _____

LEGAL OWNER (IF DIFFERENT): _____

INSURANCE CO: _____

PHONE: (_____) _____ POLICY #: _____

ADJUSTER: _____

ADDRESS: _____

PHONE: (_____) _____ CLAIM # _____

_____

WITNESS INFORMATION:

NAME: _____ D.O.B.: _____

ADDRESS: _____

HOME: (_____) _____ WORK: (_____) _____ MISC.: (_____) _____

D/L or ID NO.: _____ S.S. NO.: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: (_____) _____ OCCUPATION: _____

OBSERVATION: _____

_____

_____

_____

_____

_____

_____

_____

PERSONAL INJURY INVESTIGATION SHEET

A. Facts of the Accident: 1.)Date: _____ 2.) Time: _____ AM/PM

3.) Location: Streets: _____ City: _____

4.) Police Report: LAPD_____ CHP_____ OTHER _____ NONE _____

POLICE DEPT._____ CITY _____

REPORT NUMBER: _____

5.) Type of Accident: Rear-Ender_____ Intersection _____ Lane Change _____

Passenger Only ____ Pedestrian _____ Bicyclist _____ Slip & Fall _____

6.) Plaintiff Had: Green Light _____ Red Light _____ Yellow Light _____

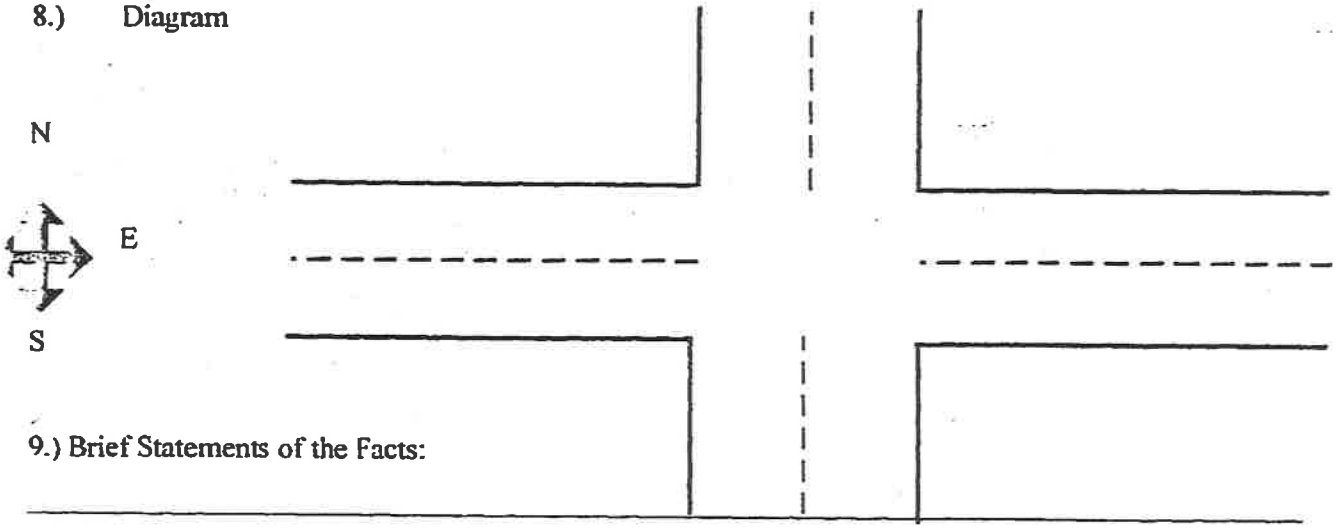
7.) Plaintiff Speed: _____ MPH Defendant Speed: _____ MPH

8.) Diagram

N

W E

S



9.) Brief Statements of the Facts:

_____

_____

_____

_____

_____

_____

10.) Was Plaintiff Taken By Ambulance to Hospital?: Yes _____ No _____

If, Yes Where: _____

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