

Letter of Protection and Notice of Lien

To Attorney: _____

RE: Patient: _____

I do hereby authorize you, my attorney, to pay directly to Kagan, Jugan & Associates ("KJA") such sums as may be due and owing it for medical services rendered me by reason of this accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect KJA. I hereby further give a Lien on my case to KJA against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I understand that KJA will not be filing a claim to my health insurance company, if one, for services rendered as a result of this accident. In the event that I am a third-party beneficiary under a contract between KJA and my health insurance carrier, I hereby voluntarily and intentionally waive and relinquish my rights, privileges and advantages as a third-party beneficiary under that contract.

I am aware and agree that KJA will NOT be billing my Health Insurance: _____

(Please Initial)

I agree never to rescind this document and that a rescission will not be honored by my attorney. 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.

I understand that if KJA has to pursue legal action to enforce this LOP against the patient and/or the attorney, the patient shall be responsible for all associated costs and attorney fees.

I fully understand that I am directly & fully responsible to KJA for all medical bills for services rendered to me and that this agreement is made solely for the additional protection of KJA and in consideration of the center's awaiting payment. I further understand that as the recipient of the medical services, I remain personally responsible for the payment of these services even if unsuccessful in my liability claim and that payment for these medical services is not contingent on any settlement, judgement or verdict I may receive. I hereby further state and agree that a photocopy of this document is deemed as valid and binding on all parties involved as the original.

Date: _____

Patient's Signature: _____

Date: _____

Witness Signature: _____

Acknowledgment of Attorney

The undersigned being attorney of record for the above patient does hereby acknowledge receipt of this Letter of Protection and agrees to abide by the terms and obligations contained herein.

Date: _____

Attorney Signature: _____

This facility holds an assignment/lien on this case for medical services rendered. Any Settlement of this claim without honoring this assignment/lien will cause you to be responsible to this facility for payment.

Fax Number: 239-936-1246