**SOHAIL SHAYFER, MD, INC.**

*Orthopaedic Surgery, Hand Surgery, & Sports Medicine*

Diplomate, American Board of Orthopaedic Surgery
**QME, State of California**

TO: Attorney_____

_____

_____

Re: Medical Lien for Services Rendered

FOR: _____ D/I:_____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself arising out of the above referenced accident.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And 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, or myself as the result of injuries for which I have been treated of injuries in connection therewith. With this understanding in mind, I agree to give said doctor information concerning any and all insurance policies, which may cover said medical treatment and assign to him, the benefits therein. I further agree to notify said doctor, and pay his billings at such time as I may personally receive payments made directly to myself for these services from my own or any other medical insurance carrier. I further agree that said doctor will be paid in full his usual and customary fees and full and final settlement will not be contingent upon any amount of payment received from said insurance carrier.

I do fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting until time of settlement or 12 months from date of accident. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. If no proceeds from settlement of legal action are received within twelve (12) months from the initial date of service, I agree to pay a minimum of $100.00 per month until we receive settlement or the balance is paid in full, whichever comes first.

I do hereby waive and fully give up my right to claim that the debts are not collectible by any reason of any applicable statute of limitations, or any other penalties caused by this delay at my request. In other words, I am giving up the right to use as an affirmative defense any statute of limitations or latches, or dismissal for delay which I may have had a right to use, for a period of ten (10) years, from the date I place my signature upon this document. I do hereby waive the right to claim that the debts are not collectible by any applicable bankruptcy filing or defence.

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It is further agreed and understood that should I, as the patient, choose to change attorneys, that this lien will be binding and in effect as if it had been signed by the new attorney. This medical lien may not be altered, modified, revoked or compromised in any way without approval of the doctor and/or medical facility and shall remain in full force and effect at all times until all moneys due have been paid. In the event that it should become necessary to assign this account to collection, the prevailing party shall be awarded full collection, legal and attorney fees.

A photocopy of this authorization shall be considered valid as the original.

DATE:_____ Patients Signature:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above. This document is being executed in triplicate and I acknowledge receipt of a copy therefore. Any dispute regarding payment and fees shall be resolved by binding arbitration and the prevailing party shall be entitled to recover full legal and attorney fees.

The undersigned attorney acknowledges that he/she is legal counsel of record for the above-named patient and that he/she agrees to bind by all of those terms of this medical lien. Said attorney agrees to notify doctor within thirty (30) days if said patient substitutes the attorney and supply the name, address and telephone number of the newly acquired attorney and specifically place said attorney on notice of pending lien. If failure to notify the doctor of such change of attorneys shall result in the doctor's failure to receive recovery pursuant to this lien, it shall be considered a breach by the undersigned attorney to the terms of this lien agreement.

DATE:_____ Attorney's signature:_____

Attorney: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records.