AIM

ATHLETIC INSTITUTE OF MEDICINE
9475 East Ironwood Square Drive #100
Scottsdale, AZ 85258
480-778-1400 • 480-778-0400 Fax

Medical Lien

AGREEMENT BY PATIENT GRANTING PHYSICIAN A LIEN AND PROMISING TO PAY PHYSICIAN FOR MEDICAL SERVICES

Patient Name: _____ DOB: _____

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

Date of Accident: _____

THIS IS A LEGAL DOCUMENT READ THE FOLLOWING CAREFULLY

I, _____ do hereby acknowledge and grant to my physician at, Athletic Institute of Medicine Of Medicine (AIM) a Lien as surety for payment for any and all medical services already rendered to me or to be rendered on my behalf, the AMOUNT of any said LIEN to be equal to the total dollar amount already billed or to be billed by said physician for ANY and ALL medical services incurred and provided to me as a result of the accident, injury or illness relating to the above. I authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for the service rendered to me. This LIEN shall be effective against ANY and ALL payment(s), settlement(s), judgement(s), award(s), claim(s), or verdict(s) made by me or to me, entered on my behalf, or agreed to by my legal representative, which relate(s) to the above-numbered claim(s), accident, injury or illness, whether or not said payments are made by 3rd party payers and/or 1st party payers under the provision of any first party agreements which injuries to my benefit, including liability, medical payment, health insurance, uninsured and under insured benefits. I UNDERSTAND that I am, and continue to be, PERSONALLY RESPONSIBLE for ANY and ALL MEDICAL BILLS presented to me by my physician, and that this agreement granting my physician a LIEN is made for valuable consideration received by me from my physician, i.e. his agreement to await payment for said medical services until said payment(s), settlement(s), judgement(s), award(s), claim(s), or verdict(s) is/are received or entered, OR until a REASONABLE TIME has passed since said medical service(s), whichever occurs FIRST. I FURTHER ACKNOWLEDGE that even if I do not receive any monies or payments as a result of my accident or illness claim(s), I HEREBY AGREE that I still owe my physician, and hereby PROMISE TO PAY my physician in a timely manner, for all medical services rendered by him to me. This PROMISE TOP PAY for medical services is NOT contingent upon any payment(s), settlement(s), judgement(s), award(s), claim(s), or verdict(s) which I may receive. I authorize AIM to sign my name to any check written in both our names where such checks are in payment for its services regarding my injury. I hereby agree that I shall not submit any of the medical bills arising out of this lien for payment for any government sponsored health plan including, but not limited to, Medicare and AHCCCS unless it is agreed by you, my said provider/doctor, to do so. Finally, this confirms that as a special consideration to you, my physician/provider, I agree that I will not seek to have you pay or share in (or be required to pay any proportional share of) any of the collection, costs, including attorney fee and costs incurred by me in obtaining the common fund recovery (the settlement, judgment, or award as to my third party claim for my accident injuries) from which you are likely to be paid as authorized pursuant to LaBombard v. Samaritan Health Systems, 195 Ariz 543, 991 P.2d 446 (App 1998). Instead, **I agree to pay the full amount** of the reasonable treatment billings to you, my said physician/provider, for treatment of my accident-related injuries, without any reduction for any proportional share of my legal fees and costs in obtaining the common fund recovery, and without reduction of your reasonable charges for any other reason (to the full extent my recovery allows). Also, this lien is enforceable under AZ law pursuant to ARS S33-931 et. dl. It is also enforceable by creating a personal contract between AIM and you and your lawyer and provides guarantees and security for payment AIM's bill for services by you and your attorney. I authorize AIM to sign my name to any check written in both our names where such checks are in payment for its services regarding my injury. This consensual lien and assignment is to continue, enforce, and be binding if I should decide to change physicians and/or attorneys in the future. I have read, fully understand, and hereby agree to this document, and hereby sign with the full intent that I be legally bound to the terms promises and conditions contained therein.

Signed: _____ Date: _____

Name of the at fault driver, insurance co, location of accident: _____

_____

Based upon information and belief, the content herein is true _____

I understand, being attorney of the record for the above names patient/client, that the above is a valid lien, I hereby acknowledge receipt of same, and I agree to honor same.

Name: _____ Attorney Signature: _____ Date: _____

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CUSTOMARY AND USUAL CHARGES/INURY INFO

You have request that we treat you for personal injuries arising from an incident where third party is apparently liable for your injuries. We have agreed to provide treatment to you under these circumstances; without limitation, based upon the following:

All services for treatment will be billed to you based upon our customary charges. A list of the most common types of treatment, and their respective customary charges, are available for your review at our front desk. **By signing below, you agree that our charges are customary and usual for our office and this geographical community.** Our agreement to treat you is contingent upon this agreement by you, and we are relying upon your agreeing not to later challenge the validity of our charges as being customary as stated herein. You agree you have had a fair opportunity to make any inquiry you desire, including consulting with an attorney, and are fully satisfied with our charges as being customary before signing below. Further, you direct any attorney who may represent you, either now or in the future, to accept our charges as being customary and specifically not to challenge our charges in any way.

YOU AGREE TO PAY, IN FULL, OUR USUAL AND CUSTOMARY TOTAL CHARGES. YOU AGREE THAT THE CHARGES LISTED AT OUR FRONT DESK, FOR YOUR REVIEW, ARE USUAL AND CUSTOMARY. YOU UNDERSTAND THAT WE ARE RELYING UPON THJIS AGREEMENT IN AGREEING TO PROVIDE TREATMENT TO YOU FOR THIS ACCIDENT CASE.

Further, you agree to furnish the following information to the best of your ability.

Patient Name: _____

Address: _____

Date of Accident: _____

Place of Accident: _____

Your insurance company: _____ Policy number: _____

Person Responsible for the Accident (Third party) Name: _____

Insurance Company (Third Party) Name: _____

Address: _____ Claim Number: _____

Adjuster Name: _____ Ph # _____ Fax # _____

Your attorney Name: _____ Contact: _____

Address: _____ Ph # _____ Fax # _____

Signature: _____ Date: _____