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: _____

AIM

ATHLETIC INSTITUTE OF MEDICINE, LTD
Thomas J. Wall, M.D., PhD
9475 E. Ironwood Square Drive, #100
Scottsdale, AZ 85258
Ph. (480) 778-1400 Fax (480) 778-0400

Lien Information

1.) Patient's Name: _____

2.) Patient's Address: _____

City: _____ State: _____ Zip Code: _____

3.) Date of accident: _____

4.) Place of accident: _____

5.) Patient's AUTO insurance: (List Only If Benefits Are Available)

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Claim Number _____

6.) Person Responsible For The Accident (Third Party) _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Policy Number: _____ Claim Number: _____

Adjuster: _____

7.) Other Insurance (driver, vehicle owner, or any insurance related to this accident).

_____

_____

8.) Your Attorney: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Contact: _____