Agreement to Doctor's Lien

Patient Name: _____

Date of Injury: _____

To Attorney or At Fault Insurance Company: _____

I understand that Camp Chiropractic Center, Inc. (CCC) will file a lien against the settlement of my injury claim with Thurston County Auditor's Office and that there will be an additional amount added to my lien for the cost of notarizing and filing that lien in the amount of $100.00. I also acknowledge that if I want CCC to release said lien when paid in full, I will be personally responsible for the additional charge of $73.00 paid in full prior to said lien being released. Furthermore, I authorize and direct my attorney or the at fault insurance company to pay to CCC all such sums as may be due and owing the clinic for said fees or treatment relating to my injury. I specifically direct my attorney or the at fault insurance company to withhold such monies out of any award or settlement that would be otherwise net payable to me when my claim for injuries resolve.

I acknowledge full responsibility for payment of all my bills owing to CCC before or at the time of settlement. I also specifically agree that CCC may withhold collection on my account in exchange for my promise to have my attorney pay my bills out of any resolution of my injury claim. I agree not to rescind the terms of this agreement therefore directing my attorney to not be bound by any attempt at rescission of this agreement on my part. I hereby direct that my attorney or the at fault insurance company pay my bill to CCC out of monies that would be otherwise net payable to me at the time of resolution of my claim.

This direction to my attorney or the at fault insurance company in no way releases me from the obligation to pay CCC on my bill, and I understand that this obligation to pay is not contingent on my recovering on my claim. I agree that if CCC is not paid on my account, CCC may take whatever collection efforts it chooses against me, and I shall be responsible for all costs of collection including reasonable attorney fees and costs incurred by CCC or its assigns in collecting monies owed by me.

If the patient is a minor or handicapped person, I represent that I am the guardian or representative of that person and have lawful authority to execute this document on that person's behalf.

Dated: _____ Patient's Name (Printed): _____

Patient's Signature: _____