

**VOLUNTARY IRREVOCABLE PHYSICIANS LIEN**

 RE: (Patient Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Accident Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For and in consideration of the professional services I am about to receive or am receiving from you, to the extent of your unpaid charges. I hereby grant you a voluntary and irrevocable lien against my share of the proceeds of any settlement or award resulting from the disposition of any claim which I may have arising from the captioned accident in which I was involved.

I hereby direct my attorney to recognize and honor this lien and to pay you directly from the proceeds allocated to me in his attorney trust account at the time he receives them. I have personally served my attorney with a copy of this lien and as principal have put my attorney, as my agent, on notice regarding his responsibility in paying you.

I hereby agree never to rescind or amend this lien and hereby agree to release you and my attorney from any claims whether in law or at equity which I may have resulting from the interpretation of this lien.

Should there be no settlement or award, I agree to remain personally responsible to pay your

charges.

**NAME OF PATIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS OF PATIENT**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SIGNATURE OF PATIENT**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE SIGNED**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACKNOWLENDGMENT OF LIEN

I hereby acknowledge the within lien and agree to be strictly bound by the terms thereof to the benefit of the physician with the understanding that the physician is placing reliance thereon.

**NAME OF ATTORNEY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS OF ATTORNEY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SIGNATURE OF ATTORNEY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE SIGNED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_