

**NOTICE OF DOCTOR'S MEDICAL LIEN**

I do hereby authorize **Craig D. Cook, D.C.** to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, e t c., of myself in regards to the accident in which I recently was involved in.

I do hereby authorize you, my attorney, to pay directly to **Craig D. Cook, D.C.** such sums as may be due to him for medical services rendered to me both by reason of this accident and by reason of any other bills do to his office and to withhold such sums from any settlement, judgment, or verdict which may be paid you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries on connection therewith.

I fully understand that I am directly and fully responsible to **Craig D. Cook, D.C** for all medical bills submitted by him for services rendered to me and that this agreement is made solely for said doctors additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or Verdict by which I may eventually recover said fee.

I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case, as if it were executed by him/her.

I agree to promptly notify the doctor of any change or addition of attorneys used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

**Please acknowledge this lien by signing below and returning to this office.**

I have been advised that if my attorney does not wish to cooperate in protecting the doctors in trust, payment will be due as services are rendered. I have also been advised that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and all other costs incurred.

Patient's Name: \_\_\_\_\_

Signature of Patient (or Parent or Guardian, if minor): \_\_\_\_\_

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

The undersigned being attorney of record for the above patient does here by agreed to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said dr. Attorney further agrees that in the event discipline is litigated, that the prevailing party will be awarded attorney fees and costs.

Attorney's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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