Element Chiropractic

1518 Bishop Rd SW
Tumwater, WA 98512
p: 360-923-5588
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Patient – Attorney
Medical Lien Agreement

I, _____ do hereby authorize Element Chiropractic to furnish you, _____my attorney, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay directly to Element Chiropractic, such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protest and pay for my treatment. I hereby grant Element Chiropractic a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided. I further understand that such payment is not contingent on my insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged. Alternate third-party payment, if accepted, is done as a courtesy provided by Element Chiropractic.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement. Furthermore, I give my attorney permission to sign this agreement at any time regardless of the date on this agreement. I understand that this agreement shall be governed by the laws of the State of Washington.

Patient Name:_____Date:_____ Doctor Name: Anthony Rodriguez, DC

Signature:_____ Signature:_____

Home Address:_____ Date: _____

_____

Phone: _____

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Attorney's Name (Print) _____ Date:_____

Attorney's Signature:_____ Sate Bar No.:_____

Address:_____

Phone:_____ Fax:_____

Email:_____