**[NAME OF CLINIC]**

**[Address 1]**

**[Address 2]**

**[Phone]**

**[Fax]**

**[Email]**

**ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN**

In consideration for deferred billing and the services rendered and/or to be rendered, I, the undersigned patient and/or responsible party, hereby irrevocably and exclusively assign and transfer to [NAME OF CLINIC AND DOCTOR] (herein after “Provider”) any and all claims, causes of action, and right to any proceeds and/or benefits that I may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred by me from Provider up to the full amount of the charges and I grant a contractual lien on proceeds of any settlement and/or judgment in any pending or future legal claim or action.

**THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.**

I acknowledge that the amount subject to this lien constitutes the ordinary and customary charges by Provider for such services, supplies and/or treatment, and may include administrative charges for costs, expenses and risk of collection typically incurred by Provider. Thus, the amount of the lien may or may not constitute the same charge of such medical services, supplies and/or treatment for similar services to others.

I authorize Provider to establish Personal Injury Protection (PIP), Med Pay and/or Uninsured Motorized (UM) claim on my behalf. I also authorize Provider to prosecute said claim and/or action either in my name or its name, as it sees fit, and further authorize it to comprise, settle, or otherwise resolve said claims as it sees fit. However, Provider shall have no duty whatsoever to prosecute the claim or litigation. Provider shall not be liable for any costs and/or expenses associated with any claims or litigation unless Provider files that litigation. Nothing herein shall prevent me from pursuing any claim or litigation that I otherwise have a right to pursue. However, I will not settle any case or claim involving recovery of Provider’s medical bills without the permission of Provider. I understand that whatever amounts Provider does not collect from insurance proceeds (whether it be all or part of what is due), I personally remain responsible and owe and agree to pay the outstanding balance in a current manner. I agree to notify Provider of any payment received by me for medical services from an insurance company or other source, and I hereby instruct my attorney, if any, to likewise notify Provider.

Any and all services rendered under this agreement shall be at the sole discretion of Provider and in no way shall this agreement be construed to obligate Provider to provide any certain services.

**INSTRUCTIONS TO INSURANCE COMPANIES:** I hereby irrevocably authorize, direct and instruct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entity (herein after referred to as “payers”), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future (herein after referred to as “condition”) to **pay directly and exclusively to [NAME OF CLINIC and DOCTOR]** such sums as may be outstanding and owed to said Provider for charges incurred by me at the office relating to my condition, with such payment **to be made by separate check and PAYABLE exclusively in the name of [NAME OF CLINIC and DOCTOR]**and deliver such payment to **[CLINIC ADDRESS]***.* Payment directly to me, even if Provider’s name is on the check, does not constitute payment to Provider and does not comply with the terms of this instruction. For the purposes of this document, “proceeds” shall include, but not be limited to, monies/proceeds from any settlement judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability insurance, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

This instruction applies irrespective of whether I have hired an attorney to pursue my other claims. In the event that I retain one or more attorneys to represent my other claims in this matter, I, nevertheless, irrevocably direct any “payer” (auto insurance and/or health insurance) to directly issue full and separate medical payment to **[NAME OF CLINIC].**

**INSTRUCTIONS TO ATTORNEYS:** In the event that I retain one or more attorneys to represent my other claims in this matter and any settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts that are outstanding on my account to Provider and remit payment of all such sums fully and directly to Provider contemporaneously with any disbursement of money to me, my attorney, or any other party from said settlement or judgment. I further irrevocably instruct and authorize my attorney to furnish to Provider any documents relating to my insurance settlement and distribution of funds, upon request of Provider, in order that Provider may be made aware of the full settlement disbursement of any recovery I may receive.

**AUTHORIZATION TO RELEASE INFORMATION:** Provider is authorized to release any information it deems appropriate concerning my physical condition and treatment to all payers as defined above or my attorneys to facilitate collection under this assignment. I further authorize and direct all payers to release to Provider all information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, the amount of settlement, and the amount of any outstanding claims. I hereby authorize and direct Provider to file a copy of this assignment, together with any applicable charges, with any or all payers and seek collection of payments, regardless of whether a claim has been established with said payers.

I also hereby grant to Provider the limited power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company for treatment and services rendered by the Provider. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to me upon request in writing to Provider.

**DEMAND FOR PAYMENT:** To any insurance company providing benefits of any kind to me/us for treatment rendered by the Provider, you are hereby tendered a demand to pay in full the bill for services rendered by Provider within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to XXXXXX of the XXXXXX, providing for attorney fees, XXXX penalty, court cost, and interest from judgment, upon violation.

**STATUTE OF LIMITATIONS:** In further consideration of deferred billing and the services rendered and/or to be rendered, I waive my right to claim any statute of limitations regarding claims for or collection of the amount due for services rendered or to be rendered by Provider, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

This assignment and contract shall not be modified or revoked without the mutual written consent of Provider and myself. I hereby revoke and resend any previously signed authorizations and assignments, whether executed at this office or any other office to the extent that the terms of those authorizations or assignments conflict with the terms of this assignment and contract:

**By my signature, I acknowledge that I have carefully read and fully understand the above document and acknowledge that it is a valid and irrevocable Assignment and Contractual Lien.**

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Signature of patient and/or responsible parties Signature on behalf of Provider

Sworn to and subscribed before me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_.

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 Notary Public in and for:

  The State of:

  My commission expires: