KINGS ANESTHESIA
PO BOX 347
ORADELL, NJ 07649
TEL: 973-546-3000 FAX: 973-546-4111

Patient Name: _____

Date of Loss: _____

Attorney Name: _____

MEDICAL LIEN

I hereby authorize and direct my attorney, to pay directly to _____ managed , such sums as may be due and owing for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to the provider and to withhold such sums from any settlement of judgment as is necessary to adequately protect the provider.

I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you my attorney.

I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Attorney agrees to notify the doctors immediately of the name and contact information of any attorney substituted in his or her place. Attorney agrees to notify the doctors when the case has settled.

_____ _____

Print Patient Name Date

_____

Signature of Patient

_____ _____

Attorney's Signature Date