DOCTOR'S LIEN

To Law Office of:

_____

_____

From: Surgical Associates of WNY, P.C.
550 Orchard Park Road, A103
West Seneca, NY 14224
Phone: (716) 677-5500
Fax: (716) 677-5008

RE: _____ SS#: _____
(Patient Name)

I hereby authorize Surgical Associates of Western New York, P.C., (Medical Services Provider) to furnish you, my attorney, with a full report of medical examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said Medical Services Provider such sums as may be due and owing them for professional services rendered me both by reason of this accident and by reason of any other bills that are due to the Medical Services Provider, and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect and compensate said Medical Services Provider. I hereby grant a lien on my case to said Medical Services Provider against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

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

Patient's Signature: _____ Date:_____

Address: _____

City, State, Zip: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said Medical Services Provider named above and to reimburse him for professional services rendered to the patient.

Attorney's Signature: _____ Date: _____

Attorney: Please date, sign and return one copy to the doctor's office at once.
Keep one copy for your records. Thank you.