SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

Attorney Name ______________________
Attorney Phone Number _______________

Patient ____________________________
DOI ________________________________

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize the above doctor's office to furnish you, my attorney, with a full report of the 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 doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. The doctor DOES NOT ACCEPT PERCENTAGES OF SAID SETTLEMENT. The said doctor will be paid in full or 100% of any outstanding bill after treatment is completed. And I hereby further give a lien on my case 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 doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Patient's Signature __________________________________ Dated ________________

The undersigned, being attorney of record for the above patient, does herby 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 to adequately protect said doctor above named A photocopy of this form shall be considered as valid as the original.

Attorney's Signature ________________________________ Dated ________________

Please date, sign and return a copy to doctor's office. Keep a copy for your records.

4611 E. SHEA BLVD, SUITE 200 • PHOENIX, AZ 85028 • (602) 265-9900 • FAX (602) 265-4130
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