DOCTOR'S LIEN
AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Doctor/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/ injury/ illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/ injury/ illness and agree to irrevocably instruct my attorney to pay you in full from and proceeds of settlement, claim or judgment related to this accident/ injury/ illness.

I also understand that if the settlement does not cover my entire bill at this clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment, which I may eventually recover.

Furthermore, in consideration for the below named Doctor/ Clinic refraining from attempting to collect immediate payment for service rendered for my accident/ injury/ illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/ Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

Family Doctor's Ramanathan, PLLC
FILE 2109
1801 W. OLYMPIC BLVD.
PASADENA, CA 91199-2109

Tel: (702) 616-9471
Fax: (702) 616-9681

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Date

INSTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctors/Clinic prior to distributing any proceeds to me, for the services that have been provided to me for the accident/injury/illness that I have agreed to pay.

_____
Firm Name

_____
Patient Signature

_____
Attorney Name

_____
Date

ATTORNEY ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my Client's instructions to Counsel and Lien and agreed to honor the same.

_____
Attorney Signature

_____
Date

DOCTOR'S LIEN

TO: ATTORNEY

_____

_____

_____

DOCTOR

Ravi S. Ramanathan
291 N. Pecos Road
Henderson, NV 89074

PATIENT: _____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her case history, examination, diagnosis, treatment, pharmaceutically dispensed medications, and prognosis in regard to my accident/injury/illness which occurred/began on:

_____
Date of Injury

I hereby give a lien to said doctor on my claim, judgment, settlement, or verdict as a result of said accident/injury/illness, and authorize and direct you, attorney, to pay directly to said doctor such sums as may be due and owing him/her for services rendered to me, and to withhold such sums from such claim, judgment, settlement, or verdict as may be necessary to protect said doctor adequately.

I fully understand I am directly and fully responsible to said doctor for all medical bills submitted by him/her for service rendered to me, and that this agreement is made solely for said doctor's additional protection, and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any claim, judgment, settlement, or verdict by which I may eventually recover said fee.

_____ _____

Signature of patient, Legal Guardian, or Personal Representative **Date**

_____ _____

Name of patient, Legal Guardian, or Personal Representative (PLEASE PRINT) **Relationship to Patient**

The understanding, being attorney or authorized representative of attorney for the above patient, does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named doctor.

_____ _____

Attorney's Signature/Authorized Representative for Attorney Date