

**Marchese Sports Therapy**

**Medical Reports & Doctor’s Lien**

RE: Accident/Injuries sustained on or about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize this doctor’s office to furnish you, my attorney with a full report of examination, diagnosis, treatment, prognosis, etc. of me 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 service 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.  I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment , or verdict which may be paid to you, my attorney, a subsequent 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 said doctor 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 fee.

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.

**Dated:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctors above named.

**Dated:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attorney’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attorney’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Please date, sign, and return one copy to doctor’s office.  Keep a copy for your records.  A photocopy of this form shall be as valid as the original.\**