NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize Clear Choice Chiropractic office the doctors and therapists of such clinic 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 recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said clinic such sums as may be due and owing the clinic for the medical service rendered to me by any and all of the office doctors and therapist listed below:

Dr. Dan Thompson, Dr. Katherine McAllister

Wynter Ostlund, LMT Jennifer Copeland-Rosenbaum, LMT Megan Linder, LMT

Both by reason of this accident and by reason of any other bills that are due to this office, doctor or therapist and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said clinic, doctors and therapists. And I hereby further give a lien on my case to said clinic, doctors and therapists against any and all proceeds of my 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 clinic office for all medical bills submitted by Clear Choice Chiropractic, their said doctors and therapists, for service rendered to me and that this agreement is made solely for said clinic's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said clinic of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

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 said clinic's interest, the clinic will not await payment and may declare the entire balance due and payable.

_____ _____

DATED PATIENT'S SIGNATURE

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 to adequately protect and fully compensate said clinic above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATE ATTORNEY SIGNATURE

Clear Choice Chiropractic 15 SW 12th Ave. BattleGround, WA 98604
Ph: (360) 666-7722 Fax: (360) 666-3388

THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

PATIENT:_____

CLAIM #: _____

DATE OF INJURY: _____

I hereby authorize and direct _____ Insurance Company to pay to Clear Choice Chiropractic PC, Inc such sums as may be due and owing them for chiropractic services rendered to me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said clinic. And I hereby further request that payment be made directly to said clinic which would otherwise be paid to myself, as the result of the treatment charges for injuries in connection therewith. This is a direct assignment of my rights and benefits under:

I fully understand that I am directly and fully responsible to said Clinic for all medical bill submitted by the doctor for services rendered to me and that this agreement is made solely for said clinic and doctor's protection and in consideration of awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

_____ _____

Date Patient's Signature

The undersigned Insurance company 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 to adequately protect and fully compensate said clinic above and below named and make payment payable directly to: Clear Choice Chiropractic, PC inc..

_____ _____

Date Signature of Insurance Company Representative

_____

Print First and Last Name

_____

Insurance Company Name

Please date, sign and return one copy to the doctor's office below:

Clear Choice Chiropractic 15 SW 12th Ave. BattleGround, WA 98604
Ph: (360) 666-7722 Fax: (360) 666-3388