# AUTHORIZATION AND MEDICAL LIEN

**iSCORE (Interventional Spine Care and Orthopedic Regenerative Experts)**
**PO Box 8323, La Crescenta, CA 91214**
**Tel: 818-338-6860; 626-460-1096; Fax: 888-425-9079**
**Office: info@iscoreinc.com; Billing: billing@iscoreinc.com**
**www.iscoreinc.com**

I, _____ desire to undergo an examination, consultation, and any potential treatment regarding any possible injuries I sustained because of an incident causing injury (hereinafter the "Claim") which occurred on or about _____. Having been counseled by the attorney of my choosing, I agree as follows:

**1. PROVIDER'S LIEN**. I hereby grant **iSCORE** (hereinafter, "Provider") a lien on my Claim against all proceeds of any settlement, judgment, verdict, or award in the amount of Provider's standard billing costs for services provided to me or a family member for whom I am responsible.

**2. ATTORNEY AUTHORIZATIONS**. I hereby authorize and direct my attorney, _____**, Esq.**, and any of my subsequent attorneys (hereinafter "Attorney"), to pay Provider all amounts owing under this lien from the proceeds of my Claim before any payments are made to me. I further authorize and direct said attorney to notify Provider of any subsequent change of representation regarding my Claim.

**3. PROVIDER AUTHORIZATIONS**. I hereby authorize Provider to furnish Attorney with all medical records pertaining to my treatment, including reports on examination, diagnosis, treatment, prognosis, and other medical bills on record.

**4. RESPONSIBILITY FOR PAYMENT**. I acknowledge that I am directly and fully responsible to Provider for all medical bills submitted for services rendered to me and that this agreement is made solely for Provider's additional protection and in consideration of Provider awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment, or verdict I may eventually receive on the Claim.

**5. INTEREST**. Provider (or Assignee) shall be entitled to receive, and I shall be required to pay, interest at the rate of ten percent (10%) per annum on all amounts owed by me for services rendered by Provider. Interest shall begin to accrue forty-five (45) days after settlement/judgment funds are received and shall continue until full payment of this Lien.

**6. MISSED APPOINTMENTS**. I have been informed and agree that if I am more than 30 minutes late to an appointment, or fail to cancel an appointment 48 hours in advance, I may be billed 50% of the scheduled appointment charge by Provider.

**7. WAIVER OF HEALTH INSURANCE**. I declare that I have thoroughly discussed with my attorney all possible sources of funding for the treatment of my injuries including, but not limited to, commercial health insurance, health management organizations, and government programs such as Workers' Compensation. I have decided that obtaining medical treatment on a lien is the best option. As such, bills for my treatment will not be submitted to any such health insurance program for payment.

**8. INTEGRATED/ENTIRE AGREEMENT**. This Agreement, and Provider's statement of fees and costs which will be generated after treatment, constitute the final, complete, and exclusive statement of the terms of the agreement between the parties and supersedes all prior and contemporaneous understandings or agreements of the parties. This agreement may only be modified by a written statement signed by Provider (or Assignee of Provider) and myself.

**9. STATUTE OF LIMITATIONS**. I hereby agree to waive the running of any Statute of Limitations for an additional period of four (4) years as provided in CCP 360.5.

**10. ACKNOWLEDGMENT**. I acknowledge by my signature that I have read this entire agreement and that all provisions, rights, and obligations have been explained to me by my attorney. As such, we consent to the terms of this contract and agree to be bound by it.

**11. COUNTERPARTS.** This Agreement may be executed in counterparts, each of which may be comprised of original signatures, or copies or facsimiles thereof, but all of which shall be taken together to constitute the same Agreement. Facsimile or emailed signatures will have the same force and effect as original signatures.

_____ Date: _____
PATIENT/ GUARDIAN SIGNATURE

_____**, Esq.** agrees that the attorney's status as trustee of the client funds will change from trustee to debtor if attorney (1) pays any other party other than Provider for Provider's services, or (2) releases/forwards said settlement, judgment or award funds directly to client without paying Provider; requiring Provider to seek payment directly from the client rather than the attorney.

_____ Date: _____
ATTORNEY SIGNATURE