Advanced Spine & Pain Interventions, LLC
12389 Crabapple Road
Alpharetta, GA 30004

P (470) 299-1998 • F (470) 299-1898 • *www.davisanesthesia.com*

MEDICAL LIEN AGREEMENT

PATIENT-ATTORNEY

I, ____ (the patient/client), hereby authorize **Advanced Spine & Pain Interventions, LLC** to furnish my attorney, ____, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay **Advanced Spine & Pain Interventions, LLC** directly, such sums of monies, which may be due and owed to them for: (a) medical services rendered to me for the injury and/or, (b) any other services, supplies, or reports, and/or (c) legal medical care (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment, as deemed necessary to adequately protect and pay for my treatment. I hereby grant **Advanced Spine & Pain Interventions, LLC** a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I understand that I am directly responsible for all medical bills submitted by the aforementioned health care provider for services rendered to me, and I acknowledge that this agreement is made solely for their additional protection in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers' compensation case, as to the appropriateness of services rendered and/or fees charged.

By signing below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement, and I contest that my attorney has advised me of the same. I understand this agreement shall be governed by the laws of the State of Georgia.

Patient/Client Signature: ____

Street Address: ____

City: ___________________________________ **State:** ________ **Zip:** ______________

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Attorney Signature: ____

State Bar No. ____ **Date:** _____________

Address: ____