RVA PHYSICAL THERAPY & SPORTS REHAB

2620 A Gaskins Rd, Henrico, VA 23238.

Fax: 888 -275-1128
Contact : (804) 396-6753
www.rvaphysicaltherapy.com

MEDICAL REPORTS & DOCTORS LIEN

I do hereby authorize RVA Physical Therapy, to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to the said doctor such sums as may be due and owing him for medical services rendered to be 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. And I hereby further give a Lien on my case to said doctor 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 agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this Lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his 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.

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 make payment on a current basis.

PRINT NAME:_____ **SIGN:**_____ **DATE:**_____

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 as may be necessary to adequately protect said doctor which is the above named.

PRINT NAME:_____ **SIGN:**_____ **DATE:**_____

Please date, sign and return the one original to the doctor's office and keep one original for your records.