Fair Oaks Chiropractic

David W. Polley D.C.
4136 Pennsylvania Avenue
Fair Oaks, CA 95628
(916) 965-4125

NOTICE OF DOCTOR'S LIEN

Patient: ______________________________ Date of Accident: ______________________________

I hereby authorize David W. Polley D.C. to furnish you, my attorney with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to David W. Polley D.C., such sums as may be due and owing him for medical services rendered me, both by reason of this accident and by reason and 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 and fully compensate said doctor. And I do hereby further give lien on my case to David W. Polley D.C., 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.

This agreement, when signed by you, my attorney, shall constitute a third party beneficiary contract, and as such, cannot be rescinded by me, and that I understand any attempted rescission will not be honored by my attorney.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 for the total amounts due David W. Polley D.C., for services rendered. I further understand and agree that this lien does not constitute any consideration for the doctor to await payment and that payments may be required from me immediately upon the rendering of services at the option of the doctor.

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 and may declare the entire balance due and payable.

______________________________ ______________________________
SIGNATURE OF PATIENT PRINTED NAME OF PATIENT

____
DATE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the medical fees of David W. Polley D.C.

______________________________ ______________________________
SIGNATURE OF ATTORNEY PRINTED NAME OF ATTORNEY

______________________________ ______________________________
STREET ADDRESS CITY, STATE, ZIP CODE

______________________________ ______________________________
PHONE NUMBER DATE