STANDARD MEDICAL SERVICE LIEN FORM

TO: Attorney: _____

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RE: Authorization Agreement to Pay Physician Fees

Date of Incident: _____

Patient Name: _____

DOCTOR:

A. Michael Moheimani, M.D.
902 N. Grand Ave., Ste 100
Santa Ana, CA 92701
Phone (714) 285-0014
Fax (714) 285-0018

On behalf of myself, and successors, I do hereby agree to pay for and authorize the above doctor to furnish you, my attorney, with full report(s) and statements of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said Doctor such sums as may be due and owing him for medical service(s), report(s), treatments and services rendered me both by reason of this incident 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 pay for and protect said doctor for all of the medical expense I have, or will, incur.

I fully understand that I am directly and personally responsible to said Doctor for payment of all medical bills represented by any statements that are submitted to me for any services rendered. I acknowledge further that this agreement is made solely for said Doctor's additional protection in the event that there remains a balance due on any such statements for any services rendered, at the time of any settlements, judgment, award, or verdict. I direct that in the event said balance due exists, that the Doctor shall be paid said full balance, without any offset or deduction, at the time of settlement, judgment, or verdict. I further understand that payment for medical services rendered by said Doctor is not contingent upon any settlement, judgment, or verdict by which I may eventually recover payments previously made to said Doctor.

I further understand that this lien does not, in any way, constitute an agreement that the above Doctor will wait for payment of his charges until settlement, award, or any legal action arising from the injuries sustained on the above date. I further understand and agree that in the event of suit on my statement with the Doctor's office, the prevailing party shall pay for attorney's fees and cost. I further understand that during the period of time that a balance remains outstanding and due said Doctor, that commercially reasonable interest shall accrue on my statement balance of one percent a month until the entire sum is paid in full. I acknowledge having read and having a copy of the above.

Please be aware that we may purchase the surgical liens, should this be a problem please inform us.

Dated: _____ **Patient's Signature:** _____

The undersigned being attorney of record for the above patient does hereby agree that this document serves as valid medical lien and agrees to observe all the terms of the above. The undersigned further agrees to abide by the ethical standards of the State Bar Rules and to first withhold such sums from any settlements, judgment award, or verdict as may be necessary to adequately protect and pay said doctor above named for all the patient's medical expenses.

Dated: _____ **Attorney's Signature:** _____

Phone Number: _____

To Attorney: Please date, sign and return one copy to the doctor's office at once.
Keep One copy for your records.