

# *VIRGINIA FAMILY CHIROPRACTIC & P.T., PLLC*

344 Maple Avenue West #231 Vienna, VA 22180-5612

## **Notice of Doctor's Lien**

I hereby authorize and direct you, my attorney \_\_\_\_\_ or \_\_\_\_\_ to pay directly to Virginia Family Chiropractic & P.T., PLLC such sums as may be due and owing this office for medical services rendered me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment or verdict and insurance payments including medical payments or P. I. P. payments as may be necessary to adequately protect and fully compensate said office.

I hereby further give a Lien on my case to Virginia Family Chiropractic & P.T., PLLC against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney and/ or insurance or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Virginia Family Chiropractic & P.T., PLLC for all medical bills submitted by this office for services rendered me and that this agreement is made solely for said office's additional protection and in consideration of their awaiting payment.

I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify Virginia Family Chiropractic & P.T., PLLC of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning it to the office. I have been advised that if my attorney and/ or insurance company does not wish to cooperate, this office will not await payment but may declare the entire balance due and payable.

**Patient's Full Name** \_\_\_\_\_

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms discussed above and agrees to withhold such sums from any settlement, judgment verdict or insurance payments including medical payment or P. I. P. payment as may be necessary to adequately protect and fully compensate said office above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney's signature \_\_\_\_\_ Date \_\_\_\_\_

