SimonMed Lien Document

Patient Name:______________________________**DOB:**___/___/____Date of Injury:____/____/_____

Attorney Name:__________________________Firm Name: ___________________________________

Address:_________________________City:____________________State:____Zip Code: ___________

Phone:_____________________Fax:___________________Email:_____________________________

Auto Insurance Company:_________________________________Adjuster's Name: _________________

Policy #:_________________________Claim #: _________________________

Phone:_____________Fax:____________Email: ________________________

I authorize the release of all my protected health information in SimonMed Imaging's possession, including reports, images, billing records, to my attorney. I hereby release SimonMed Imaging and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand it is possible that the information in my medical records may be disclosed by the recipient to other parties. This consent will expire when the case settles. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing that I notify SMI Imaging, LLC, SimonMed Imaging, Inc., SimonMed Imaging, a professional corporation (collectively SimonMed Imaging) in writing to that effect. I understand that any releases, which were made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

I hereby authorize and direct you, my attorney, to: (1) withhold from any settlement, judgment or verdict resulting from the accident in an amount equal to any and all sums I owe to SimonMed Imaging for medical services provided to me by SimonMed Imaging; and (2) pay such sums directly to SimonMed Imaging. I hereby acknowledge that SimonMed Imaging has provided and/or will provide medical services to me as a result of such injury. I hereby further give a lien on my case to SimonMed Imaging against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and solely responsible to SimonMed Imaging for all medical bills submitted for services provided to me, regardless of whether I receive any settlement, judgment or verdict as a result of the accident.

By signing and returning the below, I have been advised that if my attorney does not wish to cooperate in protecting the medical provider's interest, SimonMed Imaging will not await payment, but may declare the entire balance due and payable. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original. Please date, sign, and return one copy to SimonMed Imaging and keep one copy for your records.

_____________________________________Date: ________________________
Patient Signature

_____________________________________Date: ________________________
Attorney Signature

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above to pay SimonMed Imaging from any settlement, judgment or verdict.

Please email or fax signed Lien form to: Attorney@SimonMed.com

PI BILLING
Attorney@SimonMed.com Ph: 602-749-8599 Fax: 602-302-5810