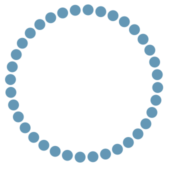

Newport Care Medical Group
3300 West Coast Hwy
Newport Beach, CA 92663
949-491-9991 (o)
949-258-5858 (f)

Notice of Doctor's Lien

Attorney____Address____

Phone_____________________________________ Fax____

Patient's Name ____Date of Injury_____________________________

I do hereby authorize **Newport Care Medical Group** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved on the above-mentioned date.

I do hereby authorize and direct you, my attorney, to pay directly to **Newport Care Medical Group,** such sums as may be due and owing for medical service rendered both by reason of this accident and by reason for any other bills that are due **Newport Care Medical Group** And I hereby further give a Lien on my case to **Newport Care Medical Group.** And I hereby further give a Lien on my case to **Newport Care Medical Group** 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/her.

I fully understand that I am directly and fully responsible to **Newport Care Medical Group** for all medical bills submitted by them for service rendered me and that this agreement is made solely for **Newport Care Medical Group.** additional protection and in consideration of their waiting payment.

I further grant permission to you, my attorney, to inform **Newport Care Medical Group** of the status of my case including all med-pay, liability, and health insurance information, and to immediately forward any medical payments receipted by your offices for services rendered by the doctor, directly to **Newport Care Medical Group,** upon receipt. This includes providing insurance contact information, claims number (s), sending a copy of the settlement draft showing the amount of settlement, a list of all outstanding lien amount with the lien holder's agreed reductions, and a listing of all attorney fees and his/her agreed fee reductions.

I also agree that **Newport Care Medical Group** be given owner if Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further agree that if I change my residence or my attorney I will notify **Newport Care Medical Group** within thirty (30) days of such changes including the new attorney's name, address and telephone number. If I do not notify **Newport Care Medical Group** within the time prescribed then I understand all monies will be due and payable immediately. The prevailing party on any action or proceeding to enforce any provision of this agreement will be awarded reasonable attorney's fees and cost incurred in that action or in efforts to settle the matter.

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 will not await payment but may declare the entire balance due and payable.

Dated: ______________________________ **X** ____

Patient's Signature

The undersigned being the attorney of records for the above patient hereby agrees to observe all terms of this lien and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect **Newport Care Medical Group** I also agree that the prevailing party in any action r proceeding to enforce any provisions of this agreement will be awarded reasonable attorney's fees and cost incurred in that action or proceeding or in effort to settle the mater.

Dated: ______________________________ **X** ____

Attorney Signature

THIS LIEN IS NOT AMENABLE OR IRREVOCABLE UNLESS APPROVED IN WRITING BY PATIENT, ATTORNEY, AND Newport Care Medical Group.

(Please date, sign and return one copy to **Newport Care Medical Group** Also keep one copy for your records.)