



Your Wellness Connection, P.A.

7410 Switzer / Shawnee Mission, KS 66203
Phone (913) 962-7408 Fax (913) 962-7416

Lien and Payment Authorization

Lien Notice to: Attorney / Firm _____ Phone # _____

Address: _____

Lien in favor of: Your Wellness Connection, P.A. and Dr. Michelle Robin.

Address: 7410 Switzer / Shawnee Mission, KS 66203

TO ATTORNEY:

1. I have requested and Your Wellness Connection, PA has agreed to render medical care/treatment to me for injuries I sustained in the accident which occurred on (date) _____ City of _____ State of _____ including: examination, diagnosis, treatment and prognosis of myself in regard to my accident.
2. I hereby give an IRREVOCABLE LIEN in favor of said Your Wellness Connection, P.A. on any settlement, claim, judgment or verdict as a result of said accident.
3. If my ATTORNEY receives any proceeds from any Insurance Company for medical services rendered me by Your Wellness Connection, P.A., I request and authorize such payment to be forwarded to Your Wellness Connection, P.A.
4. If I receive any payments from Insurance Company for medical services rendered by Your Wellness Connection, P.A., I will promptly deliver all such payments to Your Wellness Connection, P.A. If I fail to do so, the net balance is immediately due and payable to Your Wellness Connection, P.A.
5. I fully understand that I am personally responsible to Your Wellness Connection, P.A. for all the bills submitted by Your Wellness Connection, P.A. for services rendered me and that this agreement is made solely for said medical facility's additional protection from Insurance Company for medical services rendered me by said Your Wellness Connection, P.A.
6. I understand that my responsibility of payment for medical services rendered by Your Wellness Connection, P.A. is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover.
7. I hereby waive signature, in favor of Your Wellness Connection, P.A., on any check paid by said insurance.
8. I agree that a copy of this agreement is as valid and binding as the original.
9. I agree for Your Wellness Connection, P.A. to be paid in full before disbursement of monies to me.
10. I agree for this lien to be binding on any subsequent Legal Representative.

Client Name: _____ SSN# _____ - _____ - _____ File # _____

Address: _____ Phone # _____

Signature: _____ Witness: _____

ATTORNEY: The undersigned, being the attorney of record and/or authorized representative of the above client, does hereby acknowledge receipt of the above client's requests and lien, and agrees to comply with client's request regarding fees, only from monies received for client's account, for medical treatment and services rendered to the above client. I am personally responsible ONLY for any "reports" or "copies of records" that I may request.

Attorney Name (print): _____ Attorney Signature: _____

Dated: _____

(Please sign and return in the envelope provided. Keep one copy. Thank you.)

Date sent to Attorney: _____ Date Received from Attorney: _____