Family Practice Associates
a professional corporation

Eugene D. Pogorelec, D.O.
M. Terrance Simon, D.O.
Wayne H. Lutzke, D.O.

MEDICAL LIEN

I do hereby authorize Family Practice Associates, to receive payment for the examination, diagnosis, treatment and prognosis of myself in reference to the accident which necessitated their medical services.

I authorize and direct you, my attorney, to pay directly to Family Practice Associates, such sums that may be due and owing for medical services rendered to me by reason of this accident and by such sums from any judgment or verdict as may be necessary to adequately protect the health care provider represented by Family Practice associates., 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 received medical treatment.

I fully understand that I am directly and responsible to Family Practice Associates, for all medical bill submitted by them for medical services rendered to me and that this agreement is made solely for Family Practice Associates additional protection and in consideration of their awaiting payment. I also understand that payment is not contingent upon settlement, judgment or verdict.

Please acknowledge this document by signing below and returning to Family Practice Associates. I have been advised that if my attorney does not wish to cooperate in protecting Family Practice Associates interest, the doctors will not await payment but will require me to make payments on a current basis.

PATIENT'S SIGNATURE _____ DATE_____

Print Name _____

The undersigned being attorney of record for the above patient does hereby agree to observe all of the terms of the judgment or verdict as may be necessary to adequately protect the doctor's interest.

ATTORNEY'S SIGNATURE _____ DATE_____

Print Name _____

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