Coastal Pain and Spinal Diagnostics

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Coastal Pain and Spinal Diagnostics Medical Group

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Authorization and Lien

Attorney: _____

_____

_____

Patient: _____

Date of Injury: _____

I authorize Coastal Pain & Spinal Diagnostics Medical Group, Inc. to perform or cause to have performed such examinations and/ or tests and to render such treatment and prescribe such medication. I understand that treatment rendered by Coastal Pain & Spinal Diagnostics Medical Group, Inc. is under the discretion of their providers and their professional skills to assist with recovery but such recovery cannot be guaranteed, and that such physician/ physician assistant cannot be responsible for the normal risk attending medical test or treatment.

I further authorize and direct my physician/ physician assistant to furnish my attorney with detailed medical reports concerning my injuries and an itemed statement of charges incurred as a result of my accident.

I further authorize and instruct my attorney to withhold my share of the proceeds of any settlement of recovery, to pay directly to my physician such sum as may be due and owing said doctor for all medical services rendered to me, either by reason of the above accident or otherwise. Said physician is granted a lien on my client, suit or recovery for said sum.

I understand that I remain directly responsible to said doctor for his fees for medical services rendered to me, and that my obligation to pay medical fees is not contingent upon receipt of any settlement or recovery from the parties responsible for the above accident.

I waive the Statue of Limitations regarding Coastal Pain & Spinal Diagnostics Medical Group, Inc. right to recover.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____