SO CAL IMAGING AND OPEN MRI

1809 Verdugo Blvd. Suite #100
Glendale, CA 91208
Tel: 818 790 9300 Fax: 818 790 4564

PATIENT – ATTORNEY MEDICAL LIEN AGREEMENT

I do hereby authorize So Cal Imaging and Open MRI, **INC.** to furnish you, my attorney, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay directly to So Cal Imaging and Open MRI, **INC.,** such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant a lien on my claim
against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of California.

Patient Name: ____ Date of Birth: _______________

Signature: ____ Date of Injury: _______________

Home Address, City, State, Zip____

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

____ ______________________________
Attorney's Name Date

____
Attorney's Signature

State bar No.______________________ Address____
Phone Number________________________________ Fax Number_______________________________