To: Law Firm Representing the Client

From:

CitiMed Surgery Center, LLC

Place of Service
92-12 165th Street • Jamaica, NY, 11433

Billing Department
190 Midland Avenue • Saddle Brook, NJ 07663
Tel: 201-549-9998 Fax: 646-585-4468
E-mail: verification@starssi.com

Patient: _____ **DOB:** ____. ____. ____

DOL: ____. ____. ____

OUTSTANDING AMOUNT: $_____

LIEN. AUTHORIZATION OF DIRECT PAYMENT

I, Patient, hereby authorize, direct you my attorney, if any, as listed above, to pay directly to **CitiMed Surgery Center, LLC** ("**Provider**") such sums as may be necessary to adequately compensate Provider for medical services rendered to Patient by reason of this accident that are due to provider out of the funds from any compromise, settlement, arbitration, mediation, litigation or any other collection activities by Patient or my attorney. I also assign my right to receive the settlement proceeds to Provider to payment of my bill due to Provider for services rendered. I further give a lien on my case to Provider against any and all proceeds to any settlement, judgments or verdict, which shall be paid to my attorney, listed above, or myself, as the result of the injuries for which I have been treated by reason of this accident.

This agreement shell constitute an irrevocable assignment and lien on any monies collected or received as a result of the condition for which the Provider treated the Patient.

As the Patient, I fully understand that I am responsible to the Provider for all professional bills submitted for services rendered to Patient to be paid from any monies collected by reason of this accident and that this agreement is made solely for Provider's additional protection and in consideration of Provider's awaiting payment.

Prior to disbursing any settlement or recovery, the attorney listed above will verify the amount of any outstanding fees due to Provider. Also, the attorney office listed above will protect Provider's bill for services rendered to Patient out of any judgment or settlement received in a case for the above date of loss.

In addition, the attorney agrees to notify Provider within ten (10) days in the event that the Patient is assigned to other counsel.

Date: _____ *Patient's Signature:* _____

The undersigned being **attorney** of record for the above patient does hereby agree to observe all the terms and agrees to withhold any pay over such sums from any settlement, judgment, or verdict as may be adequate to protect and fully compensate CitiMed Surgery Center, LLC
Attorney further agrees that in the event this LIEN is litigated that the prevailing party will be awarded attorney's fees and cost.

Date: _____ *Attorney's Signature:* _____

To Attorney: **Please date and return one copy to the above stated CitiMed Surgery Center, LLC at once treatment can continue on the herein contain Lien basis.**

To: Law Firm Representing the Client

From:

	Sedation Vacation Perioperative Medicine, PLLC (Anesthesia Services) Place of Service 92-12 165th Street • Jamaica, NY 11433 Billing Department 200 Broadway, Brooklyn, NY 11211 Tel: 718-302-1800

Patient: _____ **DOB:** ____ - ____ - ____

DOL: ____ - ____ - ____

OUTSTANDING AMOUNT: $_____

LIEN. AUTHORIZATION OF DIRECT PAYMENT

I, Patient, hereby authorize, direct you my attorney, if any, as listed above, to pay directly to **Sedation Vacation Perioperative Medicine, PLLC ("Provider")** such sums as may be necessary to adequately compensate Provider for medical services rendered to Patient by reason of this accident that are due to provider out of the funds from any compromise, settlement, arbitration, mediation, litigation or any other collection activities by Patient or my attorney. I also assign my right to receive the settlement proceeds to Provider to payment of my bill due to Provider for services rendered. I further give a lien on my case to Provider against any and all proceeds to any settlement, judgments or verdict, which shall be paid to my attorney, listed above, or myself, as the result of the injuries for which I have been treated by reason of this accident.

This agreement shell constitute an irrevocable assignment and lien on any monies collected or received as a result of the condition for which the Provider treated the Patient.

As the Patient, I fully understand that I am responsible to the Provider for all professional bills submitted for services rendered to Patient to be paid from any monies collected by reason of this accident and that this agreement is made solely for Provider's additional protection and in consideration of Provider's awaiting payment.

Prior to disbursing any settlement or recovery, the attorney listed above will verify the amount of any outstanding fees due to Provider. Also, the attorney office listed above will protect Provider's bill for services rendered to Patient out of any judgment or settlement received in a case for the above date of loss.

In addition, the attorney agrees to notify Provider within ten (10) days in the event that the Patient is assigned to other counsel.

Date: _____ *Patient's Signature:* x__ _____

The undersigned being **attorney** of record for the above patient does hereby agree to observe all the terms and agrees to withhold any pay over such sums from any settlement, judgment, or verdict as may be adequate to protect and fully compensate Sedation Vacation Perioperative Medicine, PLLC
Attorney further agrees that in the event this LIEN is litigated that the prevailing party will be awarded attorney's fees and cost.

Date: _____ *Attorney's Signature:* _____

To Attorney: **Please date and return one copy to the above stated Sedation Vacation Perioperative Medicine, PLLC at once treatment can continue on the herein contain Lien basis.**