ANJANI SINHA MEDICAL, P.C.

16410 NORTHERN BLVD
FLUSHING, NEW YORK 11358

LIEN ASSIGNMENT AGREEMENT

I, _____

(Address), hereby enter into the following agreement with **ANJANI SINHA MEDICAL, P.C.,** for services rendered by "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered tome that were submitted on my behalf to the responsible insurance carrier as applicable.

This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all with "the provider" as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien agreement and acknowledge responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to Examinations Under Oath and Independent Medical Examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, will revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a time notice of claim to the applicable insurance carrier and that any subsequent No-fault claim denied based on the failure to provide a time notice at the election of the provider may result in recovery efforts in reliance of this lien.

The provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent applicable. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may service to invalidate any executed assignment of No-Fault benefits and result in the reliance on this for reimbursement purposes.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me or my ATTORNEY as a result of the injuries for which I have

been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby direct and authorize payment to "the provider," such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, I direct the substituted attorney to provide the incoming ATTORNEY with a copy of this lien. I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" or the attorney representing the provider prior to disbursement of any funds to ascertain any outstanding balances due to.

_____
Date

Jenester Modeste
_____
Patient Signature

_____
Attorney's Signature

_____
Patient Name (Print)

_____
Attorney's Name

_____
Patient Address

_____
Attorney's Address