UTHCM

Uptown Health Care Management, Inc.

Ambulatory Surgery Center of East Tremont Medical Center

To: Attorney: Name: _____

Address: _____

Phone: _____

RE: _____ D.O.A: _____

PATIENT'S LIEN

I do hereby authorize the above facility to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment and prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorized and direct you, my attorney, to pay directly to said facility such sums as many be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due to his/her office and to withhold such sum from any settlement, judgement, or verdict which may be paid to you, my attorney or myself as the result of the injuries which I have been treated in connection therewith.

Patient's Signature: X _____

Date: _____

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted by him for service rendered me and that this agreement is made solely for said facility, additional protection and in consideration of his awaiting payment or any settlement or verdict by which I may eventually recover said fee.

Attorney Signature: X _____

Date: _____

est Tremont Medical Center
Tremont Avenue
w York 10460
64.1633 | Fax (718) 860.0562

D/B/A New York Neuro & Rehab Center
1470 Broadway, Suite #4
New york, New York 10040
Tel (212) 5697144 | Fax (212) 569.6320

D/B/A Jerome Family Health Center
1770 jerome Avenue
Bronx, New York 10453
Tel (718) 583.3300 | Fax (718) 583.3375