COMMUNITY MEDICAL CARE OF N.Y., P.C.

1963 Grand Concourse 2nd floor
Bronx

Tel. : 718-294-5000
Fax. : 718-294-6060

AUTHORIZATION OF DIRECT PAYMENTS AND LIEN

RE:Patient Records and Lien

I do hereby authorize COMMUNITY MEDICAL CARE OF N.Y., P.C.
treatments performed on myself in regard to the accident in which I was involved on

I hereby authorize and direct you, my attorney, to pay directly to COMMUNITY MEDICAL CARE OF N.Y., P.C.
to adequately compensate COMMUNITY MEDICAL CARE OF N.Y., P.C.
reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said COMMUNITY MEDICAL CARE OF N.Y.

prior to my being seen by COMMUNITY MEDICAL CARE OF N.Y., P.C.
directed the insurance company responsible or the payment of my medical expenses to pay COMMUNITY MEDICAL CARE OF N.Y.
directly, for services rendered. I understand that I am personally and fully responsible to COMMUNITY MEDICAL CARE OF N.Y., P.C.
services rendered to me and that this agreement is made solely for the additional protection, and in consideration of
COMMUNITY MEDICAL CARE OF N.Y., P.C.

Dated: Patient's Name

Patient's Signature

The undersigned, being the attorney of record for the above patient does hereby acknowledge receipt of the above lien.

Dated: Attorney's Signature

Attorney: * Please date, sign and return one copy to our office
* Keep one copy for your records

Date:

Signature of patient or representative authorized by law