Printed on : txt_date|DATE

Patient Information

Personal Information			
First Name	txt_fname|FirstName	**Middle Name**	txt_mname|MiddleName
Last Name	txt_lname|LastName	**D.O.B**	txt_dob|DOB
Gender	txt_sex|Sex	**Address**	txt_address|Address1
City	txt_city|City	**State**	txt_state|State
Cell Phone #	txt_mob|Phone	**Home Phone**	
Work		**Zip**	txt_zip|Zip
Email	txt_eMail|eMail	**Extn.**	
Attorney	txt_attorney|Attorney	**Case Type**	txt_casetype|Compensation
Attorney Address	txt_attorneyAdd|AttorneyAdd	**Attorney Phone**	txt_attorneyPhno|AttorneyPh
Case Status		**SSN**	txt_ssn|SSN

Insurance Information			
Policy Holder		**Name**	txt_InsCo|InsCo
Address		**City**	txt_Inscity|InsCity
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	txt_ClaimNumber|ClaimNum
Policy #	txt_policy_no|policy_no		

Accident Information			
Accident Date	txt_doa|DOA	**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission	txt_doe12|LASTDOE	**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information			
Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information			
Name	txtAdjuster|Adjuster	**Phone**	
Extension		**Fax**	
Email			

UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132
usinhaorthopedics@gmail.com

I hereby direct and authorize direct payment to "the provider", such sums as may be due to 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 towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such recession. 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 and that 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.

Patient	**Attorney**
Signature: _____	**Signature:** _____
Print Name: txt_name|patientfullname	**Print Name:** txt_attorney|Attorney
Address: txt_address|Address1	**Address:** txt_attorneyAdd|AttorneyAdd
txt_city|City txt_state|State txt_zip|Zip	_____
Today's Date: txt_date|DATE	**Today's Date:** txt_a_date

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LIEN ASSIGNMENT AGREEMENT

I txt_name|patientfullname Date of Accident: txt_doa|DOA

hereby enter into the following agreement with **U.K. Sinha Physician, P.C.**, herein after known as "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 all medical bills for services rendered 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 to me 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 applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary to any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge responsibility for the repayment of all outstanding balances. 1 further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time of 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, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No Fault claim denied based on the failure to provide a timely 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 and information deemed necessary by the provider for the submission of the aforementioned insurance claims as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of my 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 orally 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.