

# **BILLY H FORD, MD, PC**

**BILLY H FORD, MD,  
Medical Director**

bhfordmdpc@gmail.com

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## **ASSIGNMENT AND LIEN**

**Date:** \_\_\_\_\_

**Claimant's Name:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_

I ("Claimant"), hereby authorize and direct my attorney ("Attorney") to pay directly and in full to **Billy H. Ford, MD, PC and/or Billy Ford, M.D.**, ("Provider") such sums as may be due and owing for medical services rendered by Provider to Claimant by reason of injuries incurred in the subject incident. **This agreement is acting as a valid assignment of Claimant's proceeds from any settlement, judgment, or verdict pertaining to the subject incident;** accordingly, this agreement is not acting as an attempted assignment of the cause of action itself. Such payment shall be drawn from any and all proceeds of any settlement, judgment or verdict that may be paid to Attorney on behalf of Claimant from the cause of action arising from the subject incident. Claimant agrees that this assignment is hereby made a lien against Claimant's claim, and such payment to Provider shall take priority over disbursement of any balance remaining to Claimant.

Provider relies upon the representation of Claimant, that Claimant has elected not to utilize Claimant's health care coverage because Claimant does not want to pay, or does not have the ability to pay, any copayments; and/or that Claimant does not want to meet and pay, or does not have the ability to meet and pay, any required deductible amounts due under the health care coverage; and/or that Claimant does not want to use health care providers within the network of providers available through Claimant health care coverage. Claimant acknowledges and understands that, regardless of whether Claimant proceeds under Claimant's health insurance coverage or through this lien, Claimant will be obligated upon recovery of expenses to pay some consideration for the medical services being provided to Claimant. Claimant affirmatively represents that no person has stated, recommended, counseled, advised or otherwise suggested to Claimant that should not utilize any health insurance coverage for treatment to be rendered to Claimant.

This lien encumbers all insurance coverages available to Claimant, of which insurer is responsible for actual coverage. Claimant authorizes Provider to disclose whatever information is necessary in order to protect and/or perfect the lien rights granted under this agreement.

In the event that other counsel is substituted for the undersigned present counsel, present counsel shall immediately notify the new/incoming counsel of this lien in writing, by certified mail, return receipt requested and shall immediately advise Provider of the name and address of new/incoming counsel in writing, by certified mail, return receipt requested. Claimant agrees and acknowledges that if Claimant changes attorneys, this agreement will remain in force and effect.

1Attorney agrees to withhold such sums from any settlement, judgment or verdict from the cause of action arising from the subject incident, and to pay directly and in full to Provider such sums as may be due and owing for medical and related services rendered by Provider to Claimant as a result of the subject incident; and Attorney shall tender payment in full to Provider before disbursing any payment to Claimant.

Claimant and Attorney agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Provider. However, should any provision of this Agreement be found to be invalid, illegal and unenforceable, or for any reason cease to be binding on any party hereto, all other provisions of this Agreement shall, nevertheless, remain in full force and effect.

Please contact **Billy H. Ford, MD PC**, 201-857-4011, kinga@maximumbilling.com or aldo@maximumbilling.com to arrange for satisfaction of this lien at the time of any resolution, specifically but not limited to any settlement or verdict.

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Claimant Name (print)

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Claimant Signature

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Date

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Custodial Parent/Legal Guardian Name (print)

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Parent/Guardian Signature

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Date

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Attorney Name (print)

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Attorney Signature

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Date