Demand Letter

TO: Attorney: Jim Lastname Esq.
123 Main

FROM: Daniel Zhong, Office Manager
Vibrant Health & Wellness Center
500 Estudillo Avenue
San Leandro, CA 94577
Ph: 510-346-2688 Fax: 510-444-3454

Date:
RE: Medical Reports and Doctor's Lien

Patient Name: Tom Anyname DOB:

Dear Jim Lastname Esq.,

I hereby request full payment related to Tom Anyname's office visits from 1/1/2000 to 3/3/2005 totaling $12345 in accordance to the doctor's lien signed by Tom Anyname dated 5/5/1999. You will find a full report of his/her examination, diagnosis, treatment, prognosis, and the invoice for all visits during the time period.

You shall send the full amount $12345 within 7 days of delivery of this letter by check or cash to:
Vibrant Health & Wellness Center
500 Estudillo Avenue San Leandro, CA 94577

Please note that a late fee of 1% per month will be assessed for any late payment.

Should you have any question, feel free to contact me.

Sincerely,

Daniel Zhong
Vibrant Health & Wellness Center

DOCTOR'S LIEN

TO: Attorney: Jim Lastname Esq.
123 Main

FROM: Daniel Zhong, Office Manager
Vibrant Health & Wellness Center
500 Estudillo Avenue
San Leandro, CA 94577
Ph: 510-346-2688 Fax: 510-444-3454

RE: Medical Reports and Doctor's Lien

Patient Name: Tom Anyname

I hereby authorize Vibrant Health and Wellness Center to furnish you, my attorney, with a full medical report and invoice of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay Vibrant Health and Wellness such sums as may be due for medical services rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement or judgment as may be necessary to adequately protect said doctor. And I hereby authorize a lien on my case to VHWC against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted for this matter, the new attorney will assume this lien in full.

I fully understand that I am directly responsible to said doctor for all medical and/or surgical benefits submitted by him/her for service rendered me. This agreement is made solely for said doctor's additional protection, and such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or courts costs will be added to the total amount due.

Please acknowledge this letter by signing below and returning to the doctor's office.

Date: _____

Dated: _____ Patient Signature: _____

Witness: _____ Address: _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs.

Date: _____ Attorney's Signature: _____

Attorney: Please date, sign and return one copy to above doctor's office at once.
Keep one copy for your records.

Billing Statement

Vibrant Health and Wellness Center
500 Estudillo Ave
San Leandro, CA
(510) 346-2688

Statement Date: 07/27/2019

Bill To: [redacted]
[redacted]
Oakland, CA 94603

Today's Date: 07/27/2019

Statement From - To : [redacted]

Patient Name: [redacted]

Date of Birth: [redacted]

Address: [redacted]

Phone: [redacted]

Provider Name: [redacted]
(DC29153, AC 10943)
EIN: 82-0661165 NPI: 1225101124

Claim #:

Notes:

Total Charges: 6174.00

Total Discount: 0.00

Total Patient Paid: [redacted]

Total Amount Used: [redacted]

Total Insurance Paid: 0.00

Statement Balance: 0.00

Past Balance:

Total Balance Due: 0.00

Date of Injury:

Diagnosis : S13 [redacted] Sprain of [redacted]

Visit Number: 1
Invoice Id: [redacted]
Visit Date: [redacted]

CPT Code	CPT Procedure	Modifiers	Units	Price
99202	Initial Evaluation		1	100.00

CPT Cost	100.00
Supplement Cost	0.00
Additionals Cost	0.00
Discount	0.00
Total	100.00
Patient Paid	100.00
Insurance Paid	0.00
Balance Due	0.00

Visit Number: 2
Invoice Id: [redacted]
Visit Date: [redacted]

CPT Code	CPT Procedure	Modifiers	Units	Price
97810	Acupuncture		1	75.00

[redacted]

CPT Cost	75.00
Supplement Cost	35.00
Additionals Cost	0.00
Discount	0.00
Total	110.00
Patient Paid	110.00
Insurance Paid	
Balance Due	

Visit Number: 3
Invoice Id: [redacted]
Visit Date: [redacted]

CPT Code	CPT Procedure	Modifiers	Units	Price
97810	Acupuncture		1	75.00

CPT Cost	75.00
Supplement Cost	0.00

[redacted] [redacted]

Additionals Cost	0.00
Discount	0.00
Total	75.00
Patient Paid	75.00
Insurance Paid	
Balance Due	

Visit Number: 4
Invoice Id: [redacted]
Visit Date: [redacted]

CPT Code	CPT Procedure	Modifiers	Units	Price
97810	Acupuncture		1	75.00

[redacted] [redacted]

[redacted] [redacted]

CPT Cost	75.00
Supplement Cost	80.00
Additionals Cost	0.00
Discount	0.00
Total	155.00
Patient Paid	155.00
Insurance Paid	
Balance Due	

Visit Number: 5
Invoice Id: [redacted]
Visit Date: [redacted]

CPT Code	CPT Procedure	Modifiers	Units	Price
97810	Acupuncture		1	75.00

[redacted] [redacted]

CPT Cost	75.00
Supplement Cost	0.00
Additionals Cost	0.00
Discount	0.00
Total	75.00
Patient Paid	75.00
Insurance Paid	0.00
Balance Due	0.00

Visit Number: 6

Date	Amount	Amount Used	Payment Type
08/06/2016	100.00	100.00	[redacted]

04/07/2018	124.39	124.39	Credit Card
[redacted]	[redacted]	[redacted]	[redacted]
09/01/2018	140.85	140.85	Credit Card
09/22/2018	123.24	123.24	Debit
10/13/2018	113.41	113.41	Credit Card
[redacted]	[redacted]	[redacted]	[redacted]