

# DOCTOR'S LIEN

To: Attorney/Insurance Carrier

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor:

Christopher C. Ninh, MD, Inc.  
11190 Warner Ave.  
Suite 306  
Fountain Valley, CA 92708-4054

RE: Patient Records and Doctor's Lien

I do hereby authorize the above named doctor to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred on \_\_\_\_\_.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for services rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by doctor for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not a contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fees.

Dated: \_\_\_\_\_ Patient's signature: \_\_\_\_\_

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect above named doctor.

Dated: \_\_\_\_\_ Authorized signature: \_\_\_\_\_

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