FREEPORT FAMILY CHIROPRACTIC CLINIC

DR. JENNIFER L. LAIRD

40 WASHINGTON STREET

FREEPORT, FL 32439

850-835-9867

LIEN

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to pay directly to Dr. Jennifer Laird,

(Patient’s Name)

Hereafter referred to as DOCTOR, of Freeport Family Chiropractic Clinic at 40 Washington Street, Freeport, Florida, 32439, such sums that may be owing them for medical services rendered me by reason of my accident of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Date)

I hereby authorize and direct you, my attorney to pay directly to said DOCTOR, any sums that may be remaining on my account with them at the time of settlement of my accident case and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the DOCTOR.

I fully understand that I am directly and fully responsible to the DOCTOR for all medical bills submitted by them for services rendered me and that this agreement is made solely for their protection and in consideration of their awaiting payment. I further understand that such payment is NOT contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

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(Date) Patient’s Name

The undersigned, being attorney of record for the above patient does hereby agree to accept 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 provider, Dr. Jennifer Laird, above names for her services rendered to my client.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE TO ATTORNEY: (1) Please date sign and return one copy to Dr. Laird’s office at the above address

(2) Please keep one for your records