LoBo Sports Chiropractic
Brothers Buck, PC
600 S. Airport Rd.
Longmont, CO 80503
Voice: (303)-776-6767
info@newleaf-chiropractic.com

NOTICE OF PHYSICIAN'S LIEN

Patient's Name:_____Date of Incident:_____

Attorney's Name and Phone Number:_____

Insurance Company and Phone Number:_____

I understand that it is the policy of LOBO SPORTS CHIROPRACTIC also known as NEW LEAF CHIROPRACTIC, and herein known as BROTHERS BUCK P.C. to have on file with this lien a letter from my personal auto insurance that I do not carry Medical Payment on my policy prior to the office accepting a Lien on my behalf for injuries sustained during a motor vehicle accident. I further understand that if my policy does carry Medical Payment Coverage, a Medical Claim must be opened for initial billing prior to the office accepting a lien for the additional bills accrued throughout my treatment.

I hereby authorize BROTHERS BUCK P.C. to furnish you with a full report and records regarding case history, examination, diagnosis, treatment and prognosis with regard to treatment related to my accident, which occurred_____.

I hereby give a lien and assignment to BROTHERS BUCK P.C. on the proceeds of my settlement, claim, judgment or verdict which results from said accident and hereby authorize, direct and instruct you, to pay directly to BROTHERS BUCK P.C. such sums as may be due and owing them for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect BROTHERS BUCK P.C. adequately and such sums as may be necessary to fully and completely pay BROTHERS BUCK P.C. any outstanding balance owed at the time of distribution of funds from any settlement, claim, judgment or verdict.

I fully understand that I am directly and fully responsible to BROTHERS BUCK P.C. for all the bills submitted by them for services rendered to me, and that this agreement is made solely for the additional protection and in consideration for said doctors awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict, which I may eventually recover. If for any reason the insurance, claim, judgment or verdict, deems that payment owed to

the providers falls on me, the patient, I am responsible for all payment owed to the providers.

I fully understand that the lien given to BROTHERS BUCK P.C. herein is irrevocable.

I _____ direct that you be bound by this lien and treat it, irrevocably, as an assignment to BROTHERS BUCK P.C. of any sums that may be due to me, to the extent and according to the terms set forth above. Be advised that BROTHERS BUCK P.C. is relying upon this lien, assignment, and directive to you, and as a result of such reliance, at my request, is providing chiropractic care and treatment for which this lien, assignment, and directive to you provides security for payment. Moreover, it is my intention that BROTHERS BUCK P.C. be viewed as a third party beneficiary of this direction to you, and I intend thereby to impose upon you an obligation to comply with the terms of this direction to you. Before you distribute any money received as a result of my case, you may make a written request and BROTHERS BUCK P.C. agrees to provide (within 30 days of your request) a written statement of my outstanding account balance including any interest thereon. BROTHERS BUCK P.C. shall be informed of the amount of any settlement, claim, judgment, or verdict, at their request.

YOU ARE HEREBY FURTHER NOTIFIED that the undersigned claims a lien, as provided under the laws of the State of Colorado relating to Physician's Lien, upon all claims and causes of action of said injured person for his reasonable charges for services rendered up to the date of payment of such damages.
In the event that there is insurance coverage, it is suggested for your protection, that this Notice of Physician's Lien be forwarded promptly to the insurance carrier.

Provider Name:_____
Provider Signature: _____
Date:_____

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TO BE SIGNED BY PATIENT:
I, _____, understand the terms of the lien above.

Patient Signature: _____
Date: _____