



Budincich Chiropractic Clinic, Inc

*Michael N. Budincich, D.C. & Associates*

140 N. Hill Avenue Pasadena, CA 91106  
(626) 792-3390 Fax (626) 792-8302

### Notice of Doctor's Lien

Attorney: \_\_\_\_\_ Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of injury: \_\_\_\_\_

I do hereby authorize Budincich Chiropractic Clinic to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc... of myself in regard to the accident dated above.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical services rendered to me both by reason of this accident and by reason or any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said clinic. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

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 in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

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

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable. A faxed copy of this form is considered as good as the original document.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_  
Patient/Guardian's signature

The undersigned being attorney of record for the above patient does hereby agree to observe all of 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 clinic above named. The attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs. In the event attorney below is "subbed out" by the patient or the attorney stops representing the patient signed above, the undersigned agrees to notify Budincich Chiropractic Clinic in writing within 5 working days by registered mail return receipt requested to the address above.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_