FYZICAL THERAPY & BALANCE CENTERS OF METROWEST
251 West Central Street, Suite 30
Natick, MA 01760
Phone: 508-650-0060
Fax: 508-650-0061

IRREVOCABLE ASSIGNMENT AND LIEN

Patient Name: Address:
Phone Number: City, State, Zip Code:
Date of Birth: Date of Injury:

This agreement is made between FYZICAL Therapy & Balance Centers of MetroWest ("Clinic") and Patient, named above, with notice to the Attorney (named below). Clinic will have a lien on all claims and causes of action of Patient regarding accident dated above and on all proceeds of any recovery, whether by settlement, arbitration award, or court judgement. This lien will secure payment of all amounts now or hereafter owed by Patient to Clinic for physical therapy/physical medicine/wellness or any service directly rendered to Patient out of such accident. Patient hereby directs Attorney to honor the lien and to pay funds secured directly to the patient no later than 30 days* after the proceeds of any recovery are received by Attorney, or two (2) years from the first date of services rendered, whichever is sooner.

Patient hereby notifies Attorney that Patient is giving Clinic a lien on these benefits or settlement proceeds. In consideration for Clinic waiting for payment, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient understands that any settlement, verdict, or judgement proceeds cannot be disbursed to Patient without first satisfying this lien. Should a dispute arise regarding payment of Clinic's charges, Patient authorizes and directs Attorney to hold in escrow all monies sufficient to satisfy this lien until the dispute can be resolved.

Patient understands and agrees that even though this lien has been given, Patient remains personally responsible for payment in full of Clinic's fees for all services rendered. Patient is solely responsible to make appropriate arrangements for payment of such fees, including but not limited to insurance benefits. Patient acknowledges that this obligation to pay Clinic's fees is not dependent on the outcome of Patient's court case.

Patient authorizes ___________________________________, ("Attorney") to keep Clinic advised of the progress of Patient's court case at reasonable intervals.

The undersigned understands fully the limited nature of this lien, and by signature agrees to its provisions complete and instructs all other parties, and agents thereof, to comply with the same.

**After 30 days, interest will be assessed at the maximum allowed by law.*

Acknowledgement by Patient

I acknowledge that this Agreement must be signed by myself before any medical services will be provided to me by Clinic.

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________
Witness/Facility Representative Date

____
Print Name & Title (if any)

To Patient's Attorney:

Attorney Name: Address:
Phone Number: City, State, Zip Code:

Please sign, date and return one copy of this Claim Agreement and Lien to FYZICAL Therapy & Balance Center of MetroWest. Keep one copy for your records. A facsimile copy will be treated as an original.

______________________________ ______________________________
Attorney's Signature Date

____
Print Name