



FAX TO: 530-273-2770
PERSONAL INJURY MEDICAL LIEN

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Tel: (530) 273-2720

TO THE LAW OFFICE OF: (Nombre de Abogado:)

TEL:

FAX:

Table with 3 columns: Patient Name, Patient ID, Date of Birth

\*\*\* INFORM YOUR ATTORNEY OF ALL PROCEDURE(S) DONE WITH INSIGHT IMAGING TO ENSURE SERVICES ARE PAID THROUGH YOUR CASE. FAILURE TO INFORM YOUR ATTORNEY MAY HOLD YOU LIABLE FOR PAYMENT OF SERVICES. INFORME A SU ABOGADO DE TODO EL PROCEDIMIENTO(S) HECHO CON INSIGHT IMAGING PARA GARANTIZAR EL PAGO DE LOS SERVICIOS A TRAVÉS DE SU CASO. DE NO INFORMAR A SU ABOGADO LE PUEDE SER RESPONSABLE PARA EL PAGO DE SERVICIOS. \*\*\*

RE: MEDICAL REPORTS AND DOCTOR'S LIEN (INFORME DE MÉDICO Y GRAVAMEN DE MÉDICO)

I hereby authorize Insight Imaging (provider) to furnish you, my Attorney, a full report of the examination, diagnosis, treatment, and prognosis in regards to the accident I was involved in on the below date(s) of injury. (Por la presente autorizo Insight Imaging (proveedor) entregar a usted, mi abogado, un informe completo del examen, diagnóstico, tratamiento y pronóstico de mí mismo, en cuando estuve envuelto en un accidente en la fecha de la herida escrito por debajo.)

I hereby authorize and direct you, my Attorney, to pay directly to Insight Imaging such sums due and owing for professional services rendered to me, both by reason of this accident and by reason of any other bills that are due and owing Insight Imaging and to withhold such sums from any settlement, judgments or verdicts as may be necessary to adequately protect and fully compensate Insight Imaging. I hereby further direct my Attorney to pay in full any medical bills owed to Insight Imaging. (Yo autorizo y le dirigo, mi abogado, para pagar directamente a Insight Imaging tales sumas como pueden ser debida y debido por servicios profesionales proveido a mí, por razón de este accidente y por razón de cualquier otras cuentas que vencen y debido a Insight Imaging y retener tales cantidades de asentamiento, fallos/verdictos o sentencias como sean necesarias para proteger adecuadamente y compensar completamente Insight Imaging. Por el presente documento, dirijo mi abogado a pagar en su totalidad cualquier facture(s) médica(s) debido a Insight Imaging.)

I fully understand that I am directly and fully responsible to Insight Imaging for all medical bills submitted by said practice for services rendered and that this agreement is made solely for said practice's additional protection and in consideration of the practice 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. I have been advised that if my attorney does not wish to cooperate in protecting Insight Imaging's interest, the practice will not await payment and may declare the entire balance due and payable. (Entiendo perfectamente que soy directamente y plenamente responsable a Insight Imaging todas las facturas médicas presentadas por dicha práctica por los servicios proveidos a mí y que este acuerdo se hace exclusivamente para protección adicional de dicha práctica y teniendo en cuenta la práctica en espera del pago. Y entiendo que dicho pago no es contingente sobre cualquier asentamiento, juicio o veredicto que finalmente puedo recuperar dicha sustantivo. Insight Imaging me ha explicado que si mi abogado no quiere cooperar en la protección de intereses de Insight Imaging, el proveedor no esperara pago (como lo haríamos con un asunto pendiente) podemos declarar la totalidad del saldo exigible y pagadera.)

I hereby agree to waive the running of any Statute of Limitations for an additional period of four (4) years as provided in CCP 360.5. Yo estoy de acuerdo de renunciar a la diversión de cualquier estatuto de limitaciones por un período adicional de cuatro (4) años como proporcionar en 360.5 CCP.

Table with 4 columns: Date(s) of Injury, Print First, Middle, & ALL Last Names, Patient's Signature, Date

Driver's Name (if you were a passenger) (Nombre de Conductor (si fue pasajero) :

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate Insight Imaging. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

Date: Attorney's Signature: