

MEDICAL PROVIDER LIEN

This form must be signed and returned to RDC Prior to services being performed.

The undersigned patient ("Patient") agrees or confirms as follows:

1. **Creation of Lien:** This document creates a medical provider lien in favor of SimonMed Reno, PLLC dba Reno Diagnostic Centers ("RDC"). This medical provider lien is effective from the date executed the Patient and shall continue until the first of the following to occur: (i) payment in full of all sums due and owing to RDC for all medical services provided by RDC to Patient associated with, or related to, the accident or injury giving rise to this lien (the "Incident"); or (ii) the date which is two years after the date of the Incident (the "Termination Date"). This lien shall terminate, be void and of no further force or effect on the Termination Date. Unless otherwise agreed in writing between RDC and Patient, on the Termination Date, Patient shall be responsible for paying all sums then due and owing to RDC for medical services provided to Patient by RDC associated with, or related to, the Incident which have not been paid prior to the Termination Date.
2. **Payment of Lien:** Patient authorizes the undersigned attorney ("Attorney") to (i) pay directly to RDC such sums as may be due and owing RDC for all medical services rendered to Patient by RDC and (ii) withhold such sums from any related settlement, judgment or verdict as may be necessary to fully pay RDC for services rendered. *Please note that all liens must be resolved on or before the Termination Date.*
3. **Release of Records:** Patient hereby authorizes RDC to furnish Attorney with a full report of Patient's case history, examination, diagnosis and treatment programs. This release includes any and all information (including billing statements) regarding the Patient's condition while under RDC's observation or treatment including history, findings and observations, office notes, progress notes and reports, examination results, correspondence, conclusions, x-ray or any other diagnostic testing readings and diagnoses, as well as any and all ultrasound, myelograms, x-rays, CAT Scans or MRI images. This authorization will expire on the Termination Date, unless revoked by Patient in writing prior to that date. Patient hereby acknowledges: (i) that he/she has the right to revoke this authorization at any time, and (ii) that he/she understands that once the information is disclosed hereunder, it may no longer be protected by federal law. Patient understands that he/she may revoke this authorization only in writing sent by certified mail to RDC at the address above. The revocation will be effective only upon receipt, except (i) to the extent RDC has acted in reliance on the authorization. Further information on the right to revoke may be provided from time to time in the Provider's Notice of Privacy Practices.
4. **Continuing Responsibility:** Patient understands that (i) Patient is directly responsible for payment to RDC for all medical services rendered by RDC to Patient, (ii) this agreement is made solely for RDC's additional security and in consideration of RDC's deferring payment, (iii) such payment by Patient is not contingent on any settlement, claim, judgment or verdict in which Patient may eventually participate, and (iv) RDC may, at any time, require immediate payment from Patient.
5. **Attorney Acknowledgment:** Patient directs Attorney to acknowledge this document by signing, dating and returning it to RDC without addendum. Patient has been advised that if Attorney does not wish to cooperate in protecting RDC's interest, RDC shall not defer payment but will require Patient to pay RDC as services are rendered.
6. **Waiver:** Patient hereby waives the applicable statute of limitations regarding RDC's right to recover payment for services rendered to Patient by RDC.

Name of Patient or Legal Guardian

Acct #

Signature of Patient or Legal Guardian

Date

The undersigned Attorney, being counsel of record for the above Patient, agrees to: (i) observe all of the foregoing terms, (ii) withhold from any settlement, judgment or verdict such amount as may be necessary to fully pay for services provided by RDC and (iii) notify RDC if Attorney is discharged or withdraws from legal representation or closes Patient's file without receiving payment.

Signature of Attorney

Date:

Print:
Name of Attorney:
Firm Name:
Phone Number:
Fax Number:
Email address:

Receipt Acknowledged By:

Signature of Authorized Representative
Reno Diagnostic Centers
PO Box 207465
Dallas, TX 75320-7465
Phone (775) 323-5083 x.3550
Fax (775) 785-8734

Date: