



IRREVOCABLE PROVIDER'S LIEN

TO ATTORNEY: _____

PATIENT: _____ D/A: _____

I DO HEREBY AUTHORIZE **RAPID REHABILITATION, INC.** TO FURNISH YOU, MY ATTORNEY, WITH A FULL REPORT OF THEIR EXAMINATION, DIAGNOSIS, TREATMENT, PROGNOSIS, ETC., OF MYSELF WITH REGARDS TO THE ACCIDENT IN WHICH I WAS INVOLVED.

I HEREBY AUTHORIZE AND DIRECT YOU, MY ATTORNEY, TO PAY DIRECT TO SAID PROVIDER SUCH SUMS AS MAY BE DUE AND OWING THEM FOR PROFESSIONAL SERVICES RENDERED ME BOTH BY REASON OF THIS ACCIDENT AND BY REASON OF ANY OTHER BILLS THAT ARE DUE THE PROVIDER AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT AND FULLY COMPENSATE SAID PROVIDER. I HEREBY FURTHER GIVE A LIEN ON MY CASE TO SAID PROVIDER AGAINST ANY AND ALL PROCEEDS OF MY SETTLEMENT, JUDGEMENT OR VERDICT WHICH MAY BE PAID TO YOU, MY ATTORNEY, OR MYSELF AS A RESULT OF THE INJURIES FOR WHICH I HAVE BEEN TREATED OR INJURIES IN CONNECTION THEREWITH.

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID PROVIDER FOR ALL PROFESSIONAL BILLS SUBMITTED BY THEM FOR SERVICES RENDERED ME AND THAT THIS AGREEMENT IS MADE SOLELY FOR SAID PROVIDER'S ADDITIONAL PROTECTION AND IN CONSIDERATION OF THEIR AWAITING PAYMENT. I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEE.

THIS LETTER IS BINDING UPON THE PATIENT AND HIS UNDERSIGNED COUNSEL, AS WELL AS THE PATIENT'S SUCCESSORS AND HEIRS, AS WELL AS, OTHER ATTORNEY WHICH THE PATIENT RETAINS. I AGREE TO PROMPTLY NOTIFY SAID PROVIDER OF ANY CHANGE OR ADDITION OF ATTORNEY(S) USED BY ME IN CONNECTION WITH THIS ACCIDENT, AND I INSTRUCT MY ATTORNEY TO DO THE SAME.

PLEASE ACKNOWLEDGE THIS LETTER BY SIGNING BELOW AND RETURNING TO THE PROVIDER'S OFFICE. I HAVE BEEN ADVISED THAT IF MY ATTORNEY DOSE NOT WISH TO COOPERATE IN PROTECTING THE PROVIDER'S INTEREST, THE PROVIDER WILL NOT AWAIT PAYMENT BUT MAY DECLARE THE ENTIRE BALANCE DUE AND PAYABLE.

DATE: _____ PATIENT SIGNATURE: _____

THE UNDERSIGNED BEING THE 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, JUDGEMENT OR VERDICT, AS MAY BE NECESSARY TO ADEQUATELY PROTECT AND FULLY COMPENSATE SAID PROVIDER ABOVE NAMED.

DATE: _____ ATTORNEY SIGNATURE: _____
PRINT NAME: _____

ATTORNEY: PLEASE NOTE THAT YOUR CLIENT HAS ALREADY SIGNIFIED CONSENT BY SIGNING THIS ORIGINAL. PLEASE DATE, SIGN, AND RETURN ONE COPY TO THE PROVIDER'S OFFICE. THE OTHER COPY IS FOR YOUR RECORDS. THANK YOU

RAPID REHABILITATION, INC.
8910 MIRAMAR PARKWAY, SUITE 115
MIRAMAR, FL 33025
TEL: 954.443.8000 • FAX: 954.443.8445