

AUTHORIZATION OF DIRECT PAYMENT AND PROVIDER'S LIEN

PROVIDER: Dr. Margaret Hudson
52 Maple Street
Florence, MA 01062

TO: _____

(Attorney's name and address)

RE: _____
(Patient Name)

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing Dr. Margaret Hudson for chiropractic services rendered me both by reason of this accident of _____ and by reason of other bills that are due Dr. Hudson's office and to withhold such sums from any proceeds due to me after payment of my attorney's fees and expenses from any settlement, judgment or verdict as may be necessary to adequately protect said provider.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by Dr. Hudson for service rendered me and that this agreement is made solely for said provider's additional protection and in consideration of her awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment or verdict by which I may eventually recover said fee. I remain personally responsible for all charges for all services rendered to me.

Client Signature _____ Date _____

Client Address _____ Witness _____

The undersigned being attorney of the record for the above client does hereby agree to observe all the terms of the above and agree to withhold such sums from any proceeds due to the above client after the payment of attorneys fees and expenses from any settlement, judgment or verdict as may be necessary to adequately protect said provider above named.

Attorney Signature _____ Date _____

Attorney: Please date, sign and return one copy to above practitioner's office.
Reply envelope attached.
Keep one copy for your records.