San Gabriel Valley Diagnostic Center
Quality Medical Imaging Since 1985

1509 w. Cameron Avenue, Suite 100
West Covina, CA 91790
P.I. Billing Dept: 626.214.2880
Main Tel: 626.962.3525
Fax: 626.214.3440
www.sgvdiagnostic.com

SAN GABRIEL VALLEY DIAGNOSTIC CENTER & BHARATH KUMAR, M.D.

NOTICE OF MEDICAL LIEN AND AUTHORIZATION

Attorney: ______________________________

Address: ______________________________

City, State, Zip: _________________________

Telephone: ____________________________

Fax #: ________________________________

Patient: ______________________________

File No: ______________________________

Date of Injury: ________________________

I, _____________________________________(patient), do hereby authorize San Gabriel Valley Diagnostic Center (SGVDC), Bharath Kumar, M.D. (Doctor) and its' agent to furnish you, my Attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved on or about ________________________(Date of Injury).

I hereby authorize and direct you, my Attorney **to pay directly to San Gabriel Valley Diagnostic Center and Bharath Kumar, M.D.** such sums as may be due and owing for medical services rendered me both by reason of accident and by reason of any other bills that are due SGVDC / Doctor in connection therewith and to withhold such sums ***IN TRUST*** from any settlement, judgment or verdict as may be necessary to adequately protect said medical facility and doctor. I also hereby knowingly and voluntarily waive the Statute of Limitations in regards to my account(s) related to the above date of injury.

I fully understand that I am **directly and fully responsible** to said medical facility and doctor for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said facility and doctors additional protection in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees. I also further understand that SGVDC and Doctor have the right to revoke this lien if in the event my attorney or myself has failed to provide said medical facility and doctor information regarding case status of my claim, as periodically requested by SGVDC, Doctor or their representatives. In the event said lien is revoked I am aware payment will be due by me for the services rendered to me.

Date: ____________________ **Patient's/Guardian Signature:** ___________________________________
Guardian Name in Print: ____

ACKNOWLEDGEMENT OF ATTORNEY

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 ***IN TRUST*** from any settlement, judgment or verdicts as may be necessary to adequately protect said medical facility and Doctor named above. Attorney further agrees to keep medical facility and doctor, informed of and to provide any requested information regarding case status. In the event this case is dropped or transferred to another Attorney, Attorney agrees to provide written notification within (10) business days of determination. In the event litigation is instituted by said medical facility and doctor to enforce its rights under this Acknowledgement of Attorney, it shall recover its reasonable attorney's fees and costs if it prevails.

Any alterations will make this agreement Null and Void.

Date: _________________________ **Attorney's Signature:** _______________________________________

California Bar No: _____________ **Attorney's Name (Please Print)** ________________________________

Please date, sign and return Original copy of this lien to the address indicated above. At the time of recovery please remit payment to the same.