

**PERSONAL INJURY LIEN FINANCIAL POLICY & SETTLEMENT RELEASE**

San Gabriel Valley Diagnostic Center &  
Bharath Kumar Krishnasamy, M.D.

1509 W. Cameron Ave., Suite D-100  
West Covina, CA 91790

Main Office T: 626.962.3525 F: 626.962.3525  
Billing Office: 626.214.2880 F: 626.214.3440

**GENERAL INFORMATION**

**DATE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_

**BILLING INFORMATION**

**Attorney's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Date of Accident:** \_\_\_\_\_

ASSIGNMENT AUTHORIZATION: I HEREBY AUTHORIZE AND DIRECT MY ATTORNEY TO PAY DIRECTLY TO THIS PROVIDER FOR ALL MEDICAL SERVICES RENDERED TO ME. I AGREE TO PAY THE BALANCE NOT PAID UNDER THIS LIEN AGREEMENT FOR SERVICES PERFORMED. I HEREBY AUTHORIZE MY ATTORNEY TO RELEASE COPIES OF MY SETTLEMENT INFORMATION, SUCH AS THE SETTLEMENT DRAFT AND DISBURSEMENT TO THESE PROVIDERS. I ALSO AUTHORIZE THIS PROVIDER TO RELEASE TO MY ATTORNEY AND INSURANCE CARRIER ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. IF DURING THE COURSE OF THE CASE THERE IS A CHANGE OF ATTORNEY OR IF THE CASE IS DROPPED, I BECOME FULLY RESPONSIBLE FOR ALL CHARGES FOR THIS PROCEDURE(S).

I UNDERSTAND I AM PERSONALLY AND FULLY RESPONSIBLE FOR ALL CHARGES.

**NOTICE: FAILURE TO PROVIDE COMPLETE INFORMATION MAY RESULT IN THE PATIENT BEING HELD FINANCIALLY RESPONSIBLE FOR SERVICE(S) RENDERED.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_