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Phoenix, Az 85016
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Lien/Letter of Protection for Medical Treatment

Patient Name (printed): ____ DOB: _________________________

I, the above referenced patient, in consideration of Az Surgery Consultants, LLC ("Provider") not pursuing collections against me for any and all amount unpaid by me or any applicable first party insurance coverage for medical treatment rendered by Provider until thirty (30) days after my settlement funds are received by me or my attorney or my case is dropped by me or my attorney, whichever occurs first. I hereby enter into this agreement and grant Provider a lien against any recovery, settlement or other consideration I may receive as a result of the incident(s) referenced above ("Provider's Lien"). Provider's Lien shall be for any and all outstanding balances for medical services rendered by Provider and received by me. I direct my attorney to withhold in trust from the net proceeds of any settlement, claim, judgment or verdict, after attorney's fees and costs, such sums as may be necessary to resolve the full amount of Provider's Lien until such time as the Provider's Lien is resolved and paid. I authorize and direct my attorney to promptly pay provider or Provider's designated representative such sums as may be due and owing Provider pursuant to this agreement. Should the attorney/client relationship terminate for any reason prior to the resolution of Provider's Lien, I direct my attorney to promptly notify, in writing, the Provider and its representatives. I understand that I am responsible for the full amount of medical bills for treatment rendered to me whether or not I receive any funds from my claims arising out of the incident(s) referenced above. This agreement is made solely for Provider's additional protection and in consideration of Provider allowing me to delay payment as per this agreement.

I hereby authorize and direct my attorney to communicate with and respond to Provider and its representatives and to promptly provide full and accurate non-privileged factual information in regard to the status of any and all of my potential claims and/or avenues of recovery arising out of the incident(s) referenced above. In the event a lien reduction is requested, I also authorize my attorney to provide non-privileged information requested by Provider, so the Provider can make an informed decision as to whether to reduce Provider's Lien. Patient acknowledges that no reduction will be considered unless the information requested is provided. Provider and its representatives agree that any such information provided would be solely for the confidential negotiation of Provider's Lien and Provider agrees to keep this information confidential and return or destroy it after resolving Provider's Lien. If Provider's Lien cannot be resolved amicably or paid in full at the conclusion of my claims arising out of the incident(s) referenced above, I direct my attorney to negotiate a pro rata distribution of my settlement proceeds or pay my net settlement funds remaining after attorney's fees and costs, up to the full amount of Provider's Lien, into the Court Registry located in the county where treatment was rendered, giving rise to Provider's Lien for judicial resolution. If I contest this agreement or Provider's Lien in the future, I direct my attorney to promptly notify the provider and/or representatives. This agreement is binding and irrevocable by Patient. Provider may revoke this agreement if Patient or Patient's attorney refuses to provide requested information or Patient changes legal representation. I acknowledge that I have read and understand the above information and all of my questions have been answered to my satisfaction. These instructions apply to any future or substituted attorney that may represent me. Furthermore, I acknowledge that I do not have applicable health insurance coverage or I am opting out of using it, which cannot be altered or revoked without the express written permission of Az Surgery Consultants, LLC.

Patient Signature: ____ Date: ______________

Date of Loss: _________________________