



## ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES

**I. Certification, Authorization and Release in Accordance with HIPAA.** Patient and Attorney of Record ("Attorney") certify that the information provided herein is correct and complete. Patient understands that, in accordance with the Health Information Portability and Privacy Act of 1996 ("HIPAA"), Patient's medical information relating to this personal injury case may be shared to manage and expedite Patient's medical treatment. Patient authorizes Patient's Physician, Attorney, and Key Health Medical Solutions, Inc. ("KHMS") and/or its affiliated medical group, Key Health Medical Group, Inc. ("KHMG") to secure, release, and disclose such medical treatment information with companies and individuals as deemed necessary, and further agrees that examinations, diagnoses, medical treatments, films and reports can be shared with necessary parties involved in Patient's case. Attorney acknowledges that Attorney has obtained a Release of Medical Information from Patient for purposes of communications regarding Patient's medical information and that KHMS/KHMG is covered by said Release.

**II. Assignment and/or Lien for Medical Services.** Patient and Attorney understand that the medical services, supplies and/or treatment Patient is receiving as part of the ongoing personal injury claim may be billed as a lien as may be authorized by applicable state law and practice. Patient hereby grants to Physician/Facility a lien on proceeds of any settlement and/or judgment in Patient's pending legal action. Patient acknowledges that Physician/Facility has assigned its right to payment and to such lien to KHMS, and that KHMS has the exclusive right to collect all amounts due for services by Physician/Facility. Patient does not have the financial resources to pay the charges at this time and patient does not have insurance coverage to cover such medical services, whereby such insurance coverage would include, but is not limited to, health insurance, Workers' Compensation, government or other medical insurance coverage. Patient and Attorney acknowledge that the amount subject to this lien constitutes the ordinary and customary charges by KHMS for such medical services, supplies and/or treatment, and may include administrative charges for costs, expenses and risk of collection typically incurred by KHMS. Thus, the amount of the lien may or may not constitute the same charge made by the actual provider of such medical services, supplies and/or treatment for similar services to others. Patient and Attorney understand that they are responsible for informing KHMS of any change in financial situation as it relates to medical care and coverage. Patient understands that Patient may seek outside independent counsel on any decision regarding the funding of Patient's medical care or for any questions Patient may have relating thereto. This lien may be signed in parts and have the same force and effect as though executed in one document. A photocopy and/or fax copy of the executed lien shall have the same force and effect as the original.

### III. Patient Information.

Attorney Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Attorney Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Key Account Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Physician/Facility: \_\_\_\_\_

*(This Assignment and Lien covers the foregoing case and any other legal or administrative action relating to the subject injury or claim.)*

**IV. Payment Agreement.** Patient authorizes and directs Attorney to pay KHMS, as assignee of KHMG and/or Physician/Facility, directly for any billings and fees arising out of the medical services, treatment and care, that have been or may be rendered to Patient by KHMG, Physician and/or Facility as a result of this incident and by reason of any other bills which Patient may owe KHMG and/or Physician/Facility. Patient understands that Patient remains personally responsible for KHMG's and/or Physician/Facility's billings and that this obligation is not contingent upon Patient's receiving any settlement for Patient's claim. Patient will notify KHMS of any payment received by Patient for medical services from an insurance company or other source, and Patient will instruct his/her attorney to likewise notify KHMS. All payments will be forwarded to KHMS. Patient further understands and accepts financial responsibility for payment of all accounts assigned to KHMS. Patient understands that the legal settlement may pay all, part, or none of Patient's account(s) and that Patient is responsible for complete payment of all account(s). Patient understands that Patient is financially responsible for any amount unpaid by this assignment of proceeds or lien, as may be authorized by applicable state law and practice. By signing this document, Patient fully understands all provisions set forth in this Agreement.

The undersigned Attorney of Record for the above-named Patient, hereby agrees to observe all terms stated herein and agrees to withhold such sum payable to KHMS, as assignee of KHMG, Physician and/or Facility, from any settlement, judgment or verdict as may be necessary to adequately protect KHMS. Attorney is expressly directed to hold in Attorney's Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay KHMS for such services by KHMG, Physician and/or Facility. Attorney is further directed to pay from Attorney's Client Trust Account to KHMS that amount which is due and owing to KHMS, as assignee, for those medical services, examinations, treatments and reports which KHMS, KHMG, and/or Facility or Physician, has had prepared on Patient's behalf. Attorney further agrees that in the event Patient secures other counsel in connection with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall inform such new counsel of the Agreement, and secure new counsel's consent thereto.

Attorney's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete and return the original to Key Health at the address below.**

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