PLEASE PRINT AND COMPLETE FORMS

Dear Patient:

It has become standard practice in the Health Care Industry and a requirement of the State of Arizona per Statute 33-931 and 33-932 to file what is known as "Notice and Claim of Health Care Provider Lien". These liens must be recorded with the County Recorders Office, by law. A copy will be sent to you by certified mail for your records, and will be released when we receive payment in full. A copy of the release will also be sent to you, via first class mail.

Please be assured that this is <u>not</u> a lien against you, or your property. This is not a reflection on your integrity and will not be picked up by credit reporting agencies for any reason, as this lien is not against you the patient, but merely a lien for payment from the responsible insurance company for your medical care costs.

At the time of settlement of your case you will receive a check/draft made out jointly to you and the Provider, at which time you are required to promptly bring the check/draft to our office for disbursement of funds.

If you have an attorney, the check will be made out to you and your attorney. Your attorney must sign an indemnifying agreement with the insurance company to pay any and all liens in full (We do not negotiate to reduce our fees.) If for some reason your settlement does not cover the cost of your care, you are personally responsible and agree to pay the balance of the bill in full.

By signing this notice you understand, and agree to the above terms.

Patients Signature:___________________________________ Date:_________________

ACCIDENT QUESTIONNAIRE

(Must be completed prior to your first visit)

Patient Name____________________________________

Date of Accident__________________________________

Address____

Location____

City/State/Zip___________________________________

Type of Accident__________________________________

MEDPAY INFORMATION

Insurance Company______________________________

Adjuster____

Address____

Adj Phone_______________________________________

City/State/Zip___________________________________

Insured's Name___________________________________

Policy Number___________________________________

Claim Number____________________________________

PARTY AT FAULT INSURANCE INFORMATION

Insurance Company______________________________

Adjuster____

Address____

Adj Phone_______________________________________

City/State/Zip___________________________________

Insured's Name___________________________________

Policy Number___________________________________

Claim Number____________________________________

ATTORNEY INFORMATION

Attorney Name___________________________________

Law Firm Name___________________________________

Address____

Phone____

City/State/Zip___________________________________

Fax____