



ATTORNEY LIEN FORM

PATIENT FIRST NAME

PATIENT LAST NAME

PATIENT DOB

ATTORNEY NAME

DATE OF INJURY

ATTORNEY ADDRESS

STREET _____

CITY _____ STATE _____

ZIP CODE _____

ATTORNEY

PHONE _____

FAX _____

EMAIL _____

1. I hereby authorize Peak Diagnostic ("Peak") to furnish my attorney with a full report of the examination performed by Peak. I hereby authorize Peak to disclose my medical information and discuss my medical condition with my attorney. 2. I understand and agree that Peak has agreed to provide services and to defer collection of its fees in reliance on my promises and the promises of my attorney as stated in this agreement. 3. I hereby direct my attorney to pay Peak for the services provided out of the funds recovered by my attorney as a result of my claims for damages against third parties. 4. I agree that my directive to my attorney to pay Peak out of the recovery is not revocable by me unless and until Peak has been paid for all services provided to me by Peak. 5. I hereby direct my attorney to provide Peak with information regarding the status of my claim against third parties upon request by Peak. Such information includes whether my case has settled, the amount of settlement, the trial date, the names of all defendants, the names of all insurance carriers and claims representatives. 6. As used in this agreement "my attorney" refers to the attorney listed in this agreement, and any subsequent attorney that I may retain in addition to or instead of my current attorney regarding my injury claims against third parties. 7. I hereby give and acknowledge that Peak shall have a lien for recovery of its charges for services provided to me and I understand that Peak may notify the court, the defendants, the involved insurance carriers and their respective attorneys of Peak's lien. 8. I agree that if I change attorneys, this agreement will remain in full force and effect and that I will notify any subsequent attorney of Peak's lien and notify Peak of the name, address and telephone number of my new attorney. 9. I understand and agree that I am personally responsible to Peak for all charges for services Peak has rendered to me if the charges are not paid out of the recovery obtained by my attorney, and that my obligation to pay Peak is not contingent on any settlement, judgment or verdict. 10. I understand and agree that this agreement is for Peak's additional protection in consideration for Peak awaiting payment for services rendered. 11. I agree to waive any statute of limitation defense as to Peak's rights to collect for the services provided by Peak, including but not limited to Code of Civil Procedure Section 360.5. 12. This agreement may be changed, altered or modified only by a separate written agreement signed by Patient and Peak. 13. Any action to enforce the provisions of this Agreement must be brought in the County of San Diego, in the State of California. Peak shall be entitled to recover its costs of collecting any moneys owed by patient, including any attorneys' fees Peak may incur.

PATIENT SIGNATURE _____ TODAY'S DATE _____

I am the attorney of record for the above-named patient. I hereby agree to observe all the terms set forth above and agree to withhold sufficient funds to pay Peak for its services from any settlement, judgment or verdict, and to pay Peak such funds prior to releasing funds to the patient named above.

ATTORNEY SIGNATURE _____ TODAY'S DATE _____