

[Name Of Medical Provider]
[Address of Medical Provider]
[Phone #] [Fax #]

PATIENT CONSENT AND DOCTOR'S LIEN

RE: Patient: _____

Date of Accident/Injury: _____

Case Name: _____

Case Number: _____

Court: _____

County of _____, State of Illinois

Consent and Authorization

The undersigned patient _____ *[insert name of patient]*, ("Patient") hereby consents to the examination, treatment, procedures and services to be performed by _____ *[insert name of medical provider]* ("Provider"), including emergency treatment.

Patient authorizes Provider to release any information needed to process the claims with respect to the examination, treatment, procedures and services rendered by Provider. Patient further directs that a photocopy of this Claim Agreement and Lien be considered as valid as the original.

Patient further authorizes _____ *[insert name of attorney]*, ("Attorney") to keep Provider advised of the progress of Patient's court case at reasonable intervals.

Irrevocable Lien

Patient hereby authorizes and directs Attorney to pay Provider directly any sums due for medical services rendered to Patient. Patient directs Attorney to withhold such funds from any settlement, verdict or judgment that is rendered in the said court case. Patient hereby notifies Attorney that Patient is giving Provider a lien on these benefits or settlement proceeds. In consideration for Provider waiting for payment, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient authorizes Provider to notify Attorney of this lien at Provider's discretion. Patient understands that any settlement, verdict or judgment proceeds cannot be disbursed to Patient without first satisfying this lien.

THIS IS A 3-PAGE FORM.