Carlsbad Imaging Center
6010 Hidden Valley Rd., Ste. 125, Carlsbad, CA 92011
Phone: 760-730-3536 Fax: 760-720-4833
www.carlsbadimaging.com

Imperial Radiology
2407 Marshall Ave., Ste. A, Imperial, CA 92251
Phone: 760-545-0340 Fax: 760-545-0341
www.imperialcountyradiology.com

Physician Services Lien

Patient Name: _____ Telephone: _____

DOB: _____Address: _____

City, State, Zip: _____

Social Security Number: _____ Employer: _____

Employer's Address: _____

Employer's Phone: _____

Attorney Representing Patient: _____

Attorney's Address: _____

Attorney's Phone Number: _____ Attorney's Fax Number: _____

Date of Injury: _____Today's Date: _____

Agreement Between Patient and Carlsbad Imaging Center & Imperial Radiology: 1. I hereby authorize Carlsbad Imaging Center ("CIC & IR") to furnish my attorney with a full report of the examination performed by CIC & IR. I hereby authorize CIC & IR to disclose my medical information and discuss my medical condition with my attorney. 2. I understand and agree that CIC & IR 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 CIC & IR 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 CIC & IR out of the recovery is not revocable by me unless and until CIC & IR has been paid for all services provided to me by CIC & IR. 5. I hereby direct my attorney to provide CIC & IR with information regarding the status of my claim against third parties upon request by CIC & IR. 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 CIC & IR shall have a lien for recovery of its charges for services provided to me and I understand that CIC & IR may notify the court, the defendants, the involved insurance carriers and their respective attorneys of CIC & IR'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 CIC & IR's lien and notify CIC & IR of the name, address and telephone number of my new attorney. 9. I understand and agree that I am personally responsible to CIC & IR for all charges for services CIC & IR has rendered to me if the charges are not paid out of the recovery obtained by my attorney, and that my obligation to pay CIC & IR is not contingent on any settlement, judgment or verdict. 10. I understand and agree that this agreement is for CIC & IR's additional protection in consideration for CIC & IR awaiting payment for services rendered. 11. I agree to waive any statute of limitation defense as to CIC & IR's rights to collect for the services provided by CIC & IR, including but not limited to Code of Civil Procedure Section 360.5. 12. This agreement may be changed, altered or modified only be a separate written agreement signed by Patient and CIC & IR. 13. Any action to enforce the provisions of this Agreement must be brought in the County of San Diego, in the State of California. CIC & IR shall be entitled to recover its costs of collecting any moneys owed by patient, including any attorneys' fees CIC & IR may incur.

Patient Signature: _____ Date Signed: _____

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Agreement Between Attorney and Carlsbad Imaging Center/Imperial Radiology:

1. I am the attorney of record for the above-named patient, I agree to pay the per study rates listed below. I also hereby agree to observe all the terms set forth above and agree to withhold sufficient funds to pay CIC & IR for its services from any settlement, judgment or verdict, and to pay CIC & IR such funds prior to releasing funds to the patient named above.

   Exam:_____ Non-negotiable cost: _____

   Exam:_____ Non-negotiable cost: _____

   Exam:_____ Non-negotiable cost: _____

   Exam:_____ Non-negotiable cost: _____

2. My office is seeking a recovery on behalf of the patient from (list all known defendants): _____ and their insurance carriers (list all known carriers, claim numbers and claims representatives):
_____
_____
_____
_____

3. My office has filed suit on behalf of the patient in the following State/U.S. District court: _____.

4. I agree to notify CIC & IR if I discontinue representing the patient or discontinue pursuing the claim on behalf of the patient.

5. I agree to provide CIC & IR with information regarding the status of the claims upon written request by CIC & IR.

Attorney Signature: _____ Date Signed: _____