Dr. Beth Cohen
740 Veterans Highway, Suite 210
Hauppauge, NY 11788
Phone: (631) 366-4474 Fax: (631) 366-4473

To: ATTORNEY _____.

_____.

_____.

Patient Name:_____ D.O.A.:_____

PATIENT'S LIEN

I do hereby authorize the above doctor to furnish to you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of my other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries which I have been treated in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____
Signature of Patient Date

The undersigned, being the attorney(s) of record for the above patient, hereby agrees to observe all the terms set forth above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the above named doctor.

_____
Attorney Name

_____ _____
Attorney Signature Date