



**PROVIDER LIEN**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Date of Injury:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I have not obtained counsel (no attorney represents me)

Attorney Name: \_\_\_\_\_ Firm's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Policy Holder:  Self -OR- Policy Holder's Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

I authorize the release of all my protected health information in Premier Mountain Imaging Center possession, including reports images, billing records, to my attorney. I hereby release Premier Mountain Imaging Center and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand it is possible that the information in my medical records may be disclosed by recipient to other parties. This consent will expire when the case is settled. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing that I notify Premier Mountain Imaging Center in writing to that effect. I understand that any releases, which were made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy / facsimile of this authorization is considered acceptable in lieu of the original.

I hereby authorize and direct you, my attorney, to: (1) withhold from any settlement, judgment or verdict resulting from the accident in an amount equal to any and all sums I owe to Premier Mountain Imaging Center for medical services provided to me by Premier Mountain Imaging Center and (2) pay such sums directly to Premier Mountain Imaging Center. I hereby acknowledge that Premier Mountain Imaging Center has provided and/or will provide medical services to me as a result of such injury. I hereby further give a lien on my case to Premier Mountain Imaging Centers against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney or myself, as a result of the injuries for the which I have been treated or injuries in connection therewith.

I fully understand that I am directly and solely responsible to Premier Mountain Imaging Center for all medical bills submitted for services provided to me, regardless of whether I receive any settlement, judgment or verdict as a result of thew accident.

By signing and returning the below, I have been advised that if my attorney does not wish to cooperate in protecting the medical provider's interest, Premier Mountain Imaging Center will not await payment, but may declare the entire balance due and payable. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original. Please date, sign, and return one copy to Premier Mountain Imaging Center and keep one copy for your records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above to pay Premier Mountain Imaging Center from any settlement, judgment or verdict.

Please email or fax signed Lien form to: [scheduling@pmicaz.com](mailto:scheduling@pmicaz.com)