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Dearborn, MI 48126
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313-584-CURE (2873)

Lien and Medical Authorization

I _____hereby grant a lien to Cure Physical Therapy (hereafter collectively referred to as "Lien Holder"). This lien takes into account any settlement, including verdict, garnishment, arbitration award, and insurance claim or payment (hereafter collectively referred to as "actions") irrespective of whether such actions relay to lien holder's bills. The lien is for the full amount of the lien holder's bill relating to me for physical therapy treatment, medical care, products, services or accommodations (collectively hereafter referred to as treatment).

I am also fully aware of the receipt, and sufficiency of the consideration for this lien in the amount of $_.00, and other valuable consideration, comprising but not limited to the following: lien holder has provided physical therapy treatment to me in the past without timely payment from me, in the future lien holder will provide treatment to me for which I am not absolutely able to make timely payment in full or for which lien holder is realistically insecure that I will be able to pay timely in full. Lienholder has, for any period of time however short, refrained from collecting the balance due from me.

I fully understand that permitting this lien does not affect or reduce in any way my personal obligation to the lien holder to timely pay for treatment.

I hereby direct my attorney(s) and agent(s) to withhold funds from any action, to first pay the lien holder the full amount of the balance owing by me as specified by the lien holder, or as much as possible with the funds available, and to abstain from making any other disbursement of funds, this include disbursements to me or on my behalf, until a time where the lien is paid in full. The directive to my attorney is irrevocable. I give consent to notify lienholder of the name of m attorney presently, and any new attorneys in the future.

For the purpose of collecting amounts owing by me, I hereby authorize lien holder to use and furnish my medical records and medical information to anyone, including but not restricted to insurance companies, and their attorneys or agents; and I also authorize lien holder and its attorneys and agents to testify or to otherwise divulge my medical records and information in any actions to collect balances owed by me.

I have read and fully comprehend this document. By signing below, I agree to it. I understand that if I decline to sign this agreement I will not be deprived presently of any emergency treatment I may need.

_____ _____

Patient Signature **Date**