LIEN AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below-named Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment from accident/injury/illness, without financial hardship, I give you a lien on any settlement, clear judgment, verdict or result of accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder, and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore, in consideration for the below-named Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Clinic of the conclusion of my efforts to obtain a settlement of judgment through the assistance of my attorney, and for a period of three (3) months thereafter.

wf | WhisperingFalls
MASSAGE THERAPY

13701 E. Sprague Ave
Spokane Valley, WA 99216
509-922-5585

Clinic Name and Address

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Date

INSTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Clinic named above in full for services to me for my accident/injury/illness from any proceeds or settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Clinic prior to distributing any proceeds to me, and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

_____
Firm Name

_____
Patient Signature

_____
Attorney Name

_____
Date