Boomerang Healthcare
Restoring Hope, Returning Health

Ph: 408.356.5292
www.boomerangHC.com

Personal Injury Lien Agreement

Patient Name: _____

Patient Address: _____

Date of Injury: _____

Attorney Name: _____

I hereby authorize Boomerang Healthcare to furnish you, my attorney, with a full report of my examination, diagnosis, prognosis, etc. with regards to the date of accident referenced above.

I hereby authorize and direct you, my attorney, to pay said center such sums as may be due and owing it for any and all medical services, treatments, evaluations, procedures, surgeries, diagnostic and therapeutic tests rendered to me at any time during the treatment both by reason of this accident and by reason of any other bills that are due to the office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said center for all bills submitted by them for services rendered to me and that this agreement is made solely for said center additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may essentially recover said fee.

I agree to promptly notify said center of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning it to Boomerang Healthcare. I have been advised that if my attorney does not wish to cooperate in protecting the center's interest, the center will not await payment but may declare the entire balance due and payable.

As the patient you are required to provide no less than 72-hour notice for all appointment cancellations, reschedules, or no shows. Failure to do so will result in a charge directly to the patient of $300.00 for a new patient visit, and $150.00 for all follow ups.

_____ _____

Patient Signature Print Name Date

_____ _____

Doctor/Doctor's Representative Date

_____ _____

Patient's Attorney Date