**Capitol Rehab**

**230 Costello Drive – Suite 1**

**Winchester, VA 22602**

**T: (540) 665-4444**

**F: (540) 665-4473**

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**ATTORNEY LIEN**

I hereby authorize and direct me attorney to pay directly to Capitol Rehab such sums as may be due and owing for chiropractic/physical therapy services rendered to me by reason of this accident, and to withhold such monies from any settlement, judgement, award, or medical payments coverage that may be necessary to adequately protect said clinic. I further give an assignment to Capitol Rehab against any and all proceeds of my settlement, judgment, award, or medical payments recovery, which may be paid to my attorney or myself as the result of my injuries from this accident.

I understand that I am directly and fully responsible to Capitol rehab for all chiropractic/physical therapy bills submitted by them for services rendered me, and that this agreement is made solely for said doctor’s additional protection and inconsideration for his/her waiting payment. I further understand that such payment is not contingent on the outcome of any settlement, judgement or award by which I may eventually recover.

Please acknowledge this letter by signing below and returning to Capitol Rehab. I have been advised that my attorney does not wish to cooperate in protecting Capitol Rehab’s interest, then the doctor will not await payment but, will require me to make payments on a current basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Name (Printed)

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

The undersigned, being attorney of record for the above patient, does hereby agree to observe all of the terms listed above and agrees to withhold such sums from any settlement, judgement, award or medical payment recovery as may be necessary to adequately protect Capitol Rehab.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attorney’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

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**Winchester, VA 22602**

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**INSURANCE LIEN**

I hereby authorize and direct the insurance company to pay directly to Capitol Rehab such sums as may be due and owing for chiropractic/physical therapy services rendered to me by reason of this accident, and to withhold such monies from and settlement, judgement, award, or medical payments coverage that may be necessary to adequately protect said clinic. I further give an assignment to Capitol Rehab against any and all proceeds of my settlement, judgement, award, or medical payments recovery, which may be paid to my attorney or me as the result of my injuries from this accident.

I understand that I am directly and fully responsible to Capitol Rehab for all chiropractic/physical therapy bills submitted by them for services rendered me, and that this agreement is made solely for said doctor’s additional protection and inconsideration for his/her awaiting payment. I further understand that such payment is not contingent on the outcome of any settlement, judgement, or award by which I may eventually recover.

Please acknowledge this letter by signing below and returning to Capitol Rehab. I have been advised that if the insurance company does not wish to cooperate in protecting Capitol Rehab’s interest, then the doctor will not await payment but, will require me to make payments on a current basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

The undersigned, being the insurance company of record for the above patient, does hereby agree to observe all of the terms listed above and agrees to withhold such sums from any settlement, judgement, award or medical payment recovery as may be necessary to adequately protect Capitol Rehab.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claims Management Specialist Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date