

MEDICAL LIEN / FINANCIAL POLICY

Please read the following carefully. This Agreement sets forth the terms for payment to the Health Care or Service Provider from whom I am about to receive services. I acknowledge and agree to adhere and abide to the entirety of this Agreement. Patient Initials _____

I [patient name] the undersigned patient does hereby give written authorization for **Truepath Imaging, LLC** to receive full reimbursement for billed charges from the settlement proceeds. An Agreement has been established with a Healthcare Provider Lien (recorded or not) and this signed Agreement is to serve as my Financial Directive and Promise to Pay; along with any and all state statutes pursuant to applicable law.

Patient Initials _____

I give my permission for **Truepath Imaging, LLC** and their agent to record and serve *Notice and Claim of Statutory Health Care Provider Lien*; my *Financial Directive and Promise to Pay* for reimbursement from the settlement funds upon all parties that are liable, including myself for damages arising from the accident which occurred on _____ [date].

Additionally, any subsequent claims arising from this accident in exchange for providing the necessary medical care without requiring payment in full for services received while awaiting my claim(s) to settle.

Patient Initials _____

I understand that by doing so I agree and will abide by the terms and conditions of this Agreement with **Truepath Imaging, LLC**. Without any delays **Truepath Imaging, LLC** will expect prompt payment of the entire amount due (no reductions accepted) on my account as first priority from all settlement/claims or financial compensation(s) regardless of how many liable payers are involved. This will include any payment(s) from past, present or future related or non-related settlements, compromises, judgments verdicts or damages.

Patient Initials _____

I agree to be legally bound and guarantee to fully reimburse **Truepath Imaging, LLC** from whom I have received services. Once **Truepath Imaging, LLC** has been fully compensated, regardless of having a recorded lien, then remaining settlements can then be distributed. I release any legal representative or anyone associated with my claim the authority to challenge the validity, enforceability or amount due to **Truepath Imaging, LLC** whether a lien has been recorded or not. Neither myself nor my attorney has already or will make a claim for reduction of my medical expenses under any state common/general fund dispersal.

Patient Initials _____

Should I retain a new attorney or terminate representation with my current attorney, I will promptly notify **Truepath Imaging, LLC** within 5 business days. In the event I proceed without any attorney, I give **Truepath Imaging, LLC** my consent to contact and negotiate directly with any applicable insurance carrier in order to satisfy this lien obligation. I further authorize and direct any and all third-party and Uninsured/Underinsured settlement to be paid directly to **Truepath Imaging, LLC**.

Patient Initials _____

I authorize any legal representative or anyone associated with my claim to make full payment promptly from any policy I may receive compensation from (UM/UIM, Third Party or any Liability Coverage).

This Agreement acknowledges I have freely given my written consent and authorization in favor of **Truepath Imaging, LLC** to be fully reimbursed without dispute or delay. I knowingly waive any and all state statutes, state or federal laws that would interfere, delay or dismiss **Truepath Imaging, LLC**, from being fully reimbursed (*customary fees and charges*). I also understand and acknowledge this Agreement is irrevocable and cannot be rescinded or amended.

Patient Initials _____

Patient Name: _____

I fully understand and agree that I am directly and fully responsible and promise to pay for all charges associated with my care. I UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY CLAIM, AGREEMENT, SETTLEMENT, COMPROMISE, JUDGMENT, VERDICT, DAMAGES, OR INSURANCE POLICY BY WHICH I MAY RECOVER SAID FEES.

Patient Initials _____

Payments will be paid directly to **Truepath Imaging, LLC**, from the settlement, whether a lien was recorded or not and regardless of the insurance companies' reimbursement, settlement or compromise. It is the policy of **Truepath Imaging, LLC** to establish a lien for my treatment. I do not have the option to utilize my health insurance as full payment for services.

Patient Initials _____

I agree to be responsible and promise to pay, but not limited to, all administrative expenses associated with processing my claim, including recording and serving notice upon all liable parties, insurance companies, government, state or federal entities which I am or will be receiving payment(s) from. Legal costs and fees, collections costs and fees incurred if necessary to collect any unpaid amount on my account.

Patient Initials _____

I [patient name], authorize all automobile insurance companies, liable insurance companies, health insurance companies or attorneys to fully disclose any information requested by **Truepath Imaging, LLC**, pertaining to my personal injury accident promptly.

Patient Initials _____

Should I change my address without notifying **Truepath Imaging, LLC**, I hereby give permission to my attorney to provide this information to **Truepath Imaging, LLC**.

Patient Initials _____

Patient Signature _____

Date _____

Legal Guardian of Patient _____

Date _____

Attorney Portion:

As Attorney for _____ [patient name], I agree to comply with this lien, assignment of benefits and claim, including, but not limited to withholding from my proceeds obtained from any agreement, settlement, compromise, judgment, verdict, damages, or insurance policy obtained on behalf of my client. As a result of this accident, you will promptly notify **Truepath Imaging, LLC**, of any changes in the status of any claim and/or lawsuit which may preclude payment of your clients' charges.

I further agree to honor all the terms stated and agreed upon above and shall withhold all sums from any settlement, judgment or verdict, as may be required by ABA Ethical Rule 1.15 (Safekeeping Property) to adequately protect **Truepath Imaging, LLC**, on behalf of said provider/facility.

Attorney Name _____

Attorney Signature _____

Date _____

Unilateral modifications or changes to this document will not be accepted.