

Medical Lien/Subrogation Contract

Roman Sibel, M.D.
2779 Horizon Ridge Parkway, #200
Henderson, Nevada 89052
Telephone 866-634-3338
Fax 702-666-0413

Date: _____ Patient Name: _____

To: _____ Patient SS#: _____
Attorney Name

I _____, hereby authorize and direct you _____
Attorney Name

My attorney to pay directly to Roman Sibel, M.D. such amounts as may be due and owing for all medical treatments or other services rendered as a result of any personal injuries I suffered on _____ . You as my attorney are further instructed to withhold such sums from my settlement, judgments', court ruling, or verdict and any other monies received as may be necessary to compensate the provider and shall tender payment in full to the provider before disbursing any payments to me.

I fully understand that I remain directly and fully responsible to the provider for payment due for all services rendered to me and that the purpose of this agreement is solely for the providers' protection and consideration for waiting for payment. I further understand that the amount I owe to the provider is not contingent upon any settlement, judgments', court ruling or verdict or any other monies received for which I may eventually recover.

My attorney is authorized to disclose information regarding the statues of my care with the provider. If my attorney refuses to honor this agreement, the provider will not wait for payment and I will be required to pay the provider in full at the time of service. It is my responsibility to keep the provider notified of any changes concerning the status of my case including in the event I change attorneys. Upon such circumstances my new attorney shall notify the provider within 48 hours of the engagement and provide in writing the the new attorney has accepted and will abide by all conditions and promises within this agreement. If the provider is not provided such notification I will be responsible for immediate payment to the provider of all balances owed to provider.

I understand that treatment will be billed on a lien basis only. I acknowledge and agree that if at any time private or public health insurance is discovered, Roman Sibel, M.D. or affiliated entities are not obligated to process the claims or accept any payment from such coverage.

Patient Signature

Attorney Signature

Print Name and Date

Print Name and Date