



**Dr. Ryan D. Kauffman**  
1136 Jacklin Rd. Milpitas, CA 95035  
Phone/Fax: (408) 262-1371

## **MEDICAL LIEN AGREEMENT**

PATIENT NAME: \_\_\_\_\_

DATE OF INJURY/INCIDENT: \_\_\_\_\_

INSURER/ADJUSTER CONTACT INFO: \_\_\_\_\_

CASE #/COURT (*LATER ADD IF NEEDED*): \_\_\_\_\_

The named Patient ("Patient") desires medical treatment by the below-named Provider, including all entities related to Provider (collectively, "Provider") for injuries sustained in the above-referenced personal injury incident ("Incident"), and has or shall be retaining the below-referenced Attorney ("Attorney") to seek compensation from a potentially liable "third party". At the request of Patient and/or Attorney, Provider agrees to a delay in being paid, by establishing a creditor-debtor relationship through this contractual Agreement, whereby Provider agrees to provide medical treatment to Patient on a "lien" basis ("Medical Lien"). Provider agrees to wait and be paid promptly upon resolution of the underlying legal matter, or, immediately upon a breach of this Agreement should Patient and/or Attorney fail to comply with the provisions of this Medical Lien.

Provider's Medical Lien is against any and all proceeds arising from the Incident, including, but not limited to, "med pay" or PIP insurance payment(s), case settlement (in whole or in part), judgment, or verdict which may be paid to Patient directly or through Attorney. In exchange for Provider agreeing to delay being fully paid, the Parties to this Medical Lien agree to each of the following:

1. That Provider may release all medical information, billings, treatment notes, etc. concerning Patient's condition and treatment to Patient's insurance company, attorney or insurance adjuster, as well as Provider's attorney or lien rep, in connection with the incident.
2. That Patient and Attorney will notify Provider in writing of any objection or issue as to Provider's fees or charges within ten (10) days of receipt of any interim or individual billing statement.
3. That no modification to this Medical Lien shall be effective unless each such modification (including any stamp, addendum or handwritten change) is initialed by Provider. If such a modification (or addendum) is attempted, but not initialed by Provider and Patient, and Patient continues to treat with Provider, then all parties signing this Medical Lien agree the Medical Lien as originally presented by Provider remains in full force and effect with the original, unmodified language as presented to the Parties by Provider.
4. That there will be no reduction of Provider's outstanding Medical Lien balance without Provider's signed written agreement to a specific dollar amount. Any request for a bill reduction should be made to Provider prior to Patient agreeing to accept any lawsuit settlement. Any reduction duly accepted by Provider is valid and enforceable, provided Provider receives the agreed upon reduction amount within 10 calendar days of Attorney's (or Patient's if no Attorney) receipt of the first settlement funds or sixty 60 calendar days from the date of Provider's written reduction agreement, whichever occurs first. Attorney (or Patient if no Attorney) shall notify Provider in writing by fax or email promptly when payment on the Medical Lien has been transmitted and is responsible for promptly confirming Provider's receipt of those funds.
5. That any transmission of partial funds by Attorney (or Patient if no Attorney) to Provider, even if stating "full and final satisfaction of Provider's lien" (or similar language), without Provider's prior written agreement to accept that reduced sum, shall not in any way be deemed an "accord and satisfaction" or otherwise limit Provider's entitlement to the full balance due and owing.



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**MEDICAL LIEN AGREEMENT (cont.)**

PATIENT NAME: \_\_\_\_\_

6. That any "med pay", PIP or similar insurance payment entitlement related to the Incident, is assigned to Provider. Attorney and Patient shall instruct the insurer to pay such entitlement directly to Provider, and if received by Attorney or Patient the recipient shall immediately send those med pay or PIP funds to Provider. Where "med pay" or PIP funds received by Provider fail to pay Provider's full bill, then Patient will remain responsible to pay the remaining balance still due and owing.
7. That if Patient's case or lawsuit does not result in a recovery sufficient to pay Provider's bill in full according to this Medical Lien, Patient agrees to remain fully liable for any remaining balance, and to promptly pay personally all remaining monies due and owing.
8. That any sums owing to Provider shall accrue interest at the rate of ten percent (10%) per annum from the date treatment is concluded until the outstanding balance is fully paid.
9. That if Provider is required to retain an attorney to recover all or part of Provider's Medical Lien, that the prevailing party in any action arising from this Agreement shall be entitled to their reasonable attorney's fees and costs, including, but not limited to, any such fees and costs incurred in pre-filing collection efforts, negotiations or any Interpleader action involving the sums due. Venue for any disputes arising under this Medical Lien shall be in the county of the State where Provider is located.
10. Provider may sell or assign the rights to this lien to a third party without restriction. The cost of any such sale or assignment shall not reduce or be deemed to reduce the amount owed on Provider's Medical Lien. Any purchaser or assignee shall have the same rights as Provider by law and under this Medical Lien.
11. That Patient directs Patient's Attorney (or Patient if no Attorney): (a) to keep Provider or Provider's designated agent informed in detail as to the progress of the underlying legal action and its potential resolution at least every three months until Provider is fully and finally paid; (b) to communicate to Provider in a timely fashion any issues with Provider's bill or any change in Attorney's representation of Patient; (c) prompt written notification of any impending resolution of any part of the lawsuit along with the amount of any settlement and a breakdown of all payouts made or intended from that settlement or case resolution if any discount is being sought; and (d) to provide any co-counsel or later substituted Attorney who will be representing Patient related to the Incident a copy of this Medical Lien with advisement that the co-counsel or new attorney is bound by this Medical Lien by virtue of the original attorney's signed agreement.

Patient has been advised that if Patient fails to follow the policies of Provider, the recommended treatment plan, or if Attorney does not cooperate in protecting Provider's Medical Lien interest or providing timely status updates of Patient's legal case, then Provider is not required to await payment and instead may declare the entire balance due and payable and take all legal action necessary to collect that outstanding balance. Any delay by Provider in the enforcement of this Agreement will not be deemed a waiver of Provider's rights and remedies in any respect.



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**MEDICAL LIEN AGREEMENT (cont.)**

PATIENT NAME: \_\_\_\_\_

**PATIENT AGREEMENT:**

Patient has read all the above, and understands and agrees to honor all terms and conditions of this Medical Lien contract. Patient has consulted with Attorney (if Attorney is retained), and should Patient retain new counsel, Patient agrees to provide that new counsel a copy of this Medical Lien prior to formal retention.

DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

**ATTORNEY AGREEMENT:**

Attorney agrees to honor all terms and conditions of this Medical Lien contract as stated above. Upon Attorney's full and timely compliance with the provisions of this Medical Lien as applies to Attorney, Attorney's fiduciary duties to Provider shall be deemed fully satisfied.

DATE: \_\_\_\_\_ LAW FIRM NAME: \_\_\_\_\_

ATTORNEY NAME: \_\_\_\_\_

ATTORNEY SIGNATURE: \_\_\_\_\_

**PROVIDER AGREEMENT:**

Provider, relying upon the representations made, and the agreement by both Patient and Attorney to all the above, agrees to accept and treat Patient, and to delay receiving payment, for services related to the injuries sustained in this Incident under the conditions stated and no others. No modification to this Agreement, or any addendum or stamp, is valid unless I approve of those changes evidenced by my signature or initials next to each such change or on any attachment.

DATE: \_\_\_\_\_ PROVIDER NAME: \_\_\_\_\_

PROVIDER SIGNATURE: \_\_\_\_\_

**Fully Signed Lien Faxed Back to Attorney (or Patient if no Attorney) On or About (DATE): \_\_\_\_\_**