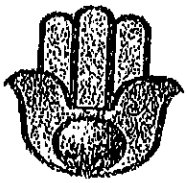
Lien

FAXED 12/7



dynamic HAND THERAPY
Hand & Upper Extremity Rehabilitation

Michelle P. Shamash, OTR/L, CHT
Certified Hand Therapist
Clinic Director

To: Hans West
From: Judy
Attn:
Date: 12/6/11
Phone:
Fax: 815-344-5280
Re: Paul Dulberg
Pages: 5
Litigation Agreement

COMMENTS:

Please have attorney sign these documents & fax back, as we require this to treat patient.

Thank you for help.

498 S. Route 12, Suite C, Fox Lake, IL 60020 Phone: 847-587-3301 Fax: 847-587-3346

LAW OFFICES OF THOMAS J. POPOVICH, P.C.

3416 West Elm Street
McHenry, IL 60050
Telephone: 815-344-3797
Facsimile: 815-344-5280

PERSONAL & CONFIDENTIAL
FACSIMILE COVER SHEET

DATE: 12/7/11

TO: Judy

FACSIMILE: 847/587-3346

FROM: Hans Mast
LAW OFFICES OF THOMAS J. POPOVICH, P.C.
3416 West Elm Street
McHenry, IL 60050

RE: Paul Dulberg

NUMBER OF PAGES: 6 (INCLUDING COVER SHEET)

MESSAGE:

Law Offices of Thomas J. Popovich, P.C.

HANS A. MAST
Attorney At Law

3416 W. Elm Street
McHenry, Illinois 60050
Phone: (815) 344-3797
Fax: (815) 344-5280

Wrongful Death
Personal Injury &
Medical Malpractice
www.popovichlaw.com
hansmast@comcast.net

Litigation Agreement and Acknowledgement of Financial Responsibility

This Litigation Agreement and Acknowledgement of Financial Responsibility is executed as of _____, 200__, by _____ ("Patient") residing at _____.

WHEREAS, Patient has been prescribed physical therapy for injuries that have occurred in a recent event;

WHEREAS, Patient is pursuing litigation to recover damages for such injury (the "Claim");

WHEREAS, FACILITY ("Clinic") is willing, as a courtesy to Patient, to delay collection of its fee for the physical/occupational therapy services rendered in order to allow Patient time to recover monetary compensation to cover the cost of the therapy services.

NOW, THEREFORE, IT IS ACKNOWLEDGED AND AGREED THAT:

Clinic agrees to refrain from attempting to collect its fees for services rendered to the Patient which are the subject of the Claim for the period set forth herein, subject to compliance by Patient with Patient's agreements and obligations as set forth herein.

Patient acknowledges and agrees that it is their sole obligation to pay for the therapy services rendered for injuries arising from the event. Patient grants a lien on and/or assigns any settlement or judgment in which Patient receives from the Claim in an amount equal to the lesser of the charges for the therapy services rendered, or the maximum amount permitted by law. Patient further agrees to execute such further documents as necessary for Clinic to preserve its right to enforce said lien and/or assignment.

Patient agrees that if the Clinic does not receive a satisfactory payment within 365 days from the date on which the last therapy services were rendered related to the Claim, Patient will pay for the therapy services without the necessity of notice or further demand. Patient acknowledges and agrees that In the event Patient does not pay for the therapy services within 395 days from the last date that the therapy services were rendered arising from the Claim, the account will be transferred to our collection agency. Patient agrees to be responsible for any expenses incurred in collecting Patient's account, including all fees, court costs, reasonable attorney's fee, and all other collection related expenses.

By signing below Patient acknowledges that he/she has read, understands and hereby accepts the above obligations and agreements.

Patient Signature: X Paul Dalby Date: 12-6-11

Written Name: _____

Acknowledgement by Clinic:

By: _____ Date: _____

Title: _____

Attachment B1.003F

HEALTH CARE PROVIDER'S LIEN

Patient: _____

I have a cause of action as a result of injuries sustained by me on _____.

I desire your services as a treating therapy facility, even though I do not have the funds to personally pay for therapy services at this time.

I understand that I am directly and fully responsible to pay you for all the reasonable and necessary medical bills incurred by me for the rendering of reasonable and necessary services provided by you. This agreement is made in consideration of your continued treatment of me, awaiting payment and foregoing collection efforts.

I give a lien to you on any settlement or jury verdict that I receive as a result of my cause of action. I authorize and direct my attorney to pay directly to you such sum as may be due for services rendered to me, and to withhold such sum from my portion of any settlement or jury verdict. In the event my portion of the recovery is insufficient to cover all of the protected medical bills in my case, then I will promptly reimburse you from my portion of the recovery on an accepted basis with all of my other protected medical bills. I further understand, however, that such pro-rata payment will not be considered payment in full by me, and that I remain fully responsible to pay the balance of my medical bill, and that any personal liability is not contingent on the settlement or jury verdict which I may recover.

Patient's Signature: X Paul Quilty Date: 12-6-11

As the patient's attorney, I acknowledge the above lien. Upon final settlement or jury verdict in this case, I agree to withhold your medical fees from the client's share of any settlement or jury verdict, and forward full payment to you.

It is expressly understood that in the event the attorney-client relationship is terminated prior to resolution of the above referenced client's case, I will immediately notify you, and I will continue to use my best efforts to ensure that your fees will be protected. I will immediately notify the appropriate insurance companies and any new attorney that the case cannot be concluded without paying your fees in accordance with this lien agreement.

Attorney's Signature: _____ Date: 12-7-11

Attachment B1.003G

LETTER OF PROTECTION
(SAMPLE)

Patient/Client:

Patient Account Number:

I hereby authorize FACILITY to furnish _____ Attorney at Law, with my complete medical records, including examination, treatment diagnosis and prognosis in regard to the accident in which I was involved. I understand that such authorization should be accompanied by an executed Authorization for Disclosure of Protected Health Information in the form attached hereto prior to FACILITY's release of such records.

I give irrevocable authorization to my attorney to pay directly to FACILITY all such sums due for therapy rendered to me as a result of the accident. I further grant a lien on and/or assign any settlement or judgment in which I receive from any claim(s) filed as a result of the accident in an amount equal to the lesser of the charges for the therapy services rendered, or the maximum amount permitted by law. I further agree to execute such further documents as necessary for FACILITY to preserve its right to enforce said lien and/or assignment.

I fully understand that I am directly and fully responsible to FACILITY for services rendered to me. This agreement is made solely for the purpose of affording FACILITY additional protection. I understand that payment of this obligation in full is not contingent on any settlement, judgment or verdict by which I may eventually recover such fees.

In addition, I understand and agree that payment in full on my account should be made within _____ months of this date unless other financial arrangements have been made. I understand that my account shall be forwarded to FACILITY's collection agency in the event I do not timely pay the account or make other financial arrangements. I further understand that the obligations recited herein (including the obligation to pay for services rendered) shall continue in full force and effect, and shall be binding upon me, my heirs, administrators, executors, successors, and assigns, until and unless all fees for services rendered have been paid in full.

X _____ 12-6-11

Guarantor's Signature Date

_____

Witness's Signature

The undersigned attorney of record for the patient, does agree to observe all terms of this letter of Protection, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect FACILITY.

_____ 12-6-11

Attorney Signature Date

** Transmit Conf. Report **

P.1
LAW OFFICE T POPOVICH Fax 1-815-344-5280 Dec 7 2011 12:50pm

Fax/Phone Number	Mode	Start	Time	Page	Result	Note
18475873346	Normal	07:12:49pm	1'01"	6	# 0 K	

LAW OFFICES OF THOMAS J. POPOVICH, P.C.

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PERSONAL & CONFIDENTIAL
FACSIMILE COVER SHEET

DATE: 12/7/11

TO: Judy

FACSIMILE: 847/587-3346

FROM: Hans Hast
LAW OFFICES OF THOMAS J. POPOVICH, P.C.
3416 West Elm Street
McHenry, IL 60050

RE: Paul Dulberg

NUMBER OF PAGES: 6 (INCLUDING COVER SHEET)

MESSAGE:

CONFIDENTIALITY NOTICE