SimonMed Consensual Lien Agreement

Patient Name: ____________________________ D.O.B.____/____/____ Date of Injury: ____/____/____

Attorney Name: _________________________ Firm Name: ___________________________________

Address: _______________________________ City: ___________ State: _____ Zip code: ________

Phone: ____________________________ Fax: _____________ Email: _________________________

Billing Information: Please initial <u>one</u> choice to indicate billing preference.

_____ I elect to not have SimonMed Imaging bill my health insurance for services performed at SimonMed Imaging. I understand that I am responsible for the full billed charges of my imaging. In addition, I agree that SimonMed Imaging is entitled to a consensual lien as described in A.R.S. § 33-931(F) to collect any unpaid charges from funds from any settlement, judgment or award I receive as a result of the incident which led to my injuries. I understand that SimonMed will **not** bill my health insurance for these services at a future date.

_____ I elect to bill my health insurance for all services performed at SimonMed Imaging. I understand that my exam may be postponed and rescheduled awaiting authorization. I understand I am responsible for any deductible, copay, coinsurance, and billed charges for any non-covered services as determined by my health insurance. In addition, I agree that SimonMed Imaging is entitled to a consensual lien as described in A.R.S. § 33-931(F) to collect any unpaid deductible, copay, coinsurance, and billed charges for any non-covered services from funds from any settlement, judgment or award I receive as a result of the incident which led to my injuries

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_____ I do not have health insurance. I understand that I am responsible for the full billed charges of my imaging. In addition, I agree that SimonMed Imaging is entitled to a consensual lien as described in A.R.S. § 33-931(F) to collect any unpaid charges from funds from any settlement, judgment or award I receive as a result of the incident which led to my injuries.

_____ I elect to bill my auto insurance for all services performed at SimonMed Imaging. I understand that I am responsible for the full billed charges not paid by my auto insurance. In addition, I agree that SimonMed Imaging is entitled to a consensual lien as described in A.R.S. § 33-931(F) to collect any unpaid charges from funds from any settlement, judgment or award I receive as a result of the incident which led to my injuries.

Your Auto Insurance Company: ___________________________ Adjusters Name: ________________

Policy #: ___________________________ Claim #: ____

Phone: ___________________________ Fax: __________________ Email: ______________________

I fully understand that I am directly and solely responsible for all unpaid charges billed by SimonMed Imaging for services provided to me, regardless of whether I receive any settlement judgment or award as a result of the accident.

<u>Authorization to Release Protected Health Information to Attorney</u>

I authorize the release of all my protected health information in SimonMed Imaging's possession, including reports, images, billing records, to my attorney named above. I hereby release SimonMed Imaging and its employees from any and all liability for fulfilling the authorization request for release of medical information. I understand it is possible that the information in my medical records may be disclosed by the recipient to other parties. This consent will expire when the case is settled. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing that I notify SMI Imaging, LLC, SimonMed Imaging, Inc., SimonMed Imaging, a professional corporation (collectively SimonMed Imaging) in writing to that effect. I understand that any releases, which were made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

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Authorization for Attorney to Withhold Settlement or Judgment Funds to Pay SimonMed Imaging

I hereby authorize and direct my attorney named above to (1) withhold from any settlement, judgment or award resulting from the accident in an amount equal to any and all unpaid charges owing to SimonMed Imaging for medical services provided to me by SimonMed Imaging; and (2) pay such sums directly to SimonMed Imaging. I hereby acknowledge that SimonMed Imaging has provided and/or will provide medical services to me as a result of such injury. I hereby further give a lien on my case to SimonMed Imaging against any and all proceeds of my settlement, judgment, or award which may be paid to SimonMed Imaging, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

By signing and returning the below, I have been advised that if my attorney does not wish to cooperate in protecting the medical provider's interest, SimonMed Imaging will not await payment, but may declare the entire balance due and payable. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

Please date, sign, and return one copy to SimonMed Imaging and keep one copy for your records.

Patient Signature: ____ Date: ______________________

Please email this completed Consensual Lien Agreement to attorney@simonmed.com or fax to 602-302-5999

PI Billing Department