

## **Allegiance Orthopedic and Spine Institute, PLLC**

101 NW 1<sup>st</sup> Ave, Suite B

Delray Beach, FL 33444

**Phone: 561-330-4358 Fax: 561-330-4390**

### *Lien and Letter of Protection*

*I hereby authorize and direct my attorneys (whether now or hereafter representing me) to pay directly to Allegiance Orthopedic and Spine Institute, PLLC, all sums due and owing for all services rendered by Allegiance Orthopedic and Spine Institute, PLLC, including but not limited to, medical services rendered, supplies provided, reports made or duplicated, depositions given, or time spent as an expert or witness in my case. I hereby give and grant unto Allegiance Orthopedic and Spine Institute, PLLC a first priority lien upon and to any and all monies that I may have the right to or benefit of, or come to have the right to or benefit of, from any source whatsoever, including but not limited to any settlement, judgment, recovery, or other source of funds, to the extent of all sums owed by me to Allegiance Orthopedic and Spine Institute, PLLC stemming from my care or treatment, or any case I may institute involving, in whole or part, said care or treatment. This lien is prior in dignity and superior to any right in any such funds that anyone else may possibly claim, including my attorney(s). I authorize and hereby instruct my attorneys to withhold such sums from any insurance settlement, judgment, verdict or other source of funds that I may have the right to or benefit of, or come to have the right to or benefit of, as may be necessary to fully pay and adequately protect Allegiance Orthopedic and Spine Institute, PLLC as first priority lien or thereon, including all funds owed to me from my case by way of the tort feisor(s), insurance payments, judgment, verdict, or other source which may be paid to my attorney or myself.*

*I fully understand that I am personally and directly fully responsible to Allegiance Orthopedic and Spine Institute, PLLC for all medical bills for services rendered to me, whether or not submitted to any insurer or other entity for payment in whole or part. I further understand that this agreement is made solely for my protection in consideration of Allegiance Orthopedic and Spine Institute, PLLC providing me care and treatment that I believe to be reasonable to obtain or medically necessary, from my perspective as the patient, and for Allegiance Orthopedic and Spine Institute, PLLC awaiting payment for set said care and treatment. **The physicians of Allegiance Orthopedic and Spine Institute, PLLC may contract with an insurance plan that they or I participate in; however, this provider may or may not elect to bill my insurance or accept payment(s) from that insurance company, and in any event, I hereby waive any right I might be perceived to have to request or require that Allegiance Orthopedic and Spine Institute, PLLC or any of its physician submit any bills to any insurance carrier.** I understand that nothing herein releases me from my absolute and ultimate responsibility and obligation to pay Allegiance Orthopedic and Spine Institute, PLLC in full for services rendered. I further understand that my obligation of payment is not contingent on any settlement, judgment, verdict, or anything else whatsoever.*

*I agree to keep Allegiance Orthopedic and Spine Institute, PLLC apprised of the name and address of all attorneys who represents me. Notification of any such changes must be made to Allegiance Orthopedic and Spine Institute, PLLC within ten (10) days, and in any event, before any case or claim settlement is made, or any funds are paid (whether by a tort feisor, insurance company, or any other payor whatsoever) to me, or to my attorney(s) on my behalf. I instruct any/all attorney(s) who represent me to honor this agreement and fulfill it, whether or not they sign a copy of this Lien and Letter of Protection, and also understand that if my attorney does not wish to cooperate in protecting Allegiance Orthopedic and Spine Institute, PLLC such does not change the attorney's signature on this document is not necessary for the instructions I give him/her herein to bind said attorney. In the event of my attorneys' failure to cooperate despite my instructions made herein (to which Allegiance Orthopedic and Spine Institute, PLLC) is an express, intended, third-party beneficiary), such will be a breach by me of this agreement entitling Allegiance Orthopedic and Spine Institute, PLLC to all remedies available at law and in equity, and Allegiance Orthopedic and Spine Institute, PLLC will be immediately released from any obligations under this agreement, including that it shall not have to await payment and can require me to pay the account on a current basis.*

*By my signature below I establish that I have read, understood, and consented to the terms of this agreement.*

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**Patient Name**

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**Patient Signature**

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**Date**

**Allegiance Orthopedic and Spine Institute, PLLC**

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Patients name: \_\_\_\_\_

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DATE OF ACCIDENT: \_\_\_\_\_

*In the event any dispute arises as to charge for any services rendered by Allegiance Orthopedic and Spine Institute, PLLC. I hereby authorized and direct my attorney to withhold from any source of funds that I may have the right to or benefit of, or come to have the right to or benefit of, the full sum claimed by Allegiance Orthopedic and Spine Institute, PLLC until said time as the matter is settled by compromise or judgment. I also agree that I shall be responsible for all costs, including attorneys' fees and costs of collection, incurred by Allegiance Orthopedic and Spine Institute, PLLC whether or not there be any litigation between us involving or concerning this agreement, such costs, including attorneys' fees and collection costs, to be payable by me to Allegiance Orthopedic and Spine Institute, PLLC on demand.*

*The undersigned, being the attorney for above patient, does hereby recognize the instructions given me by the patient, my client, and I do agree to observe all the terms of the above and agree to withhold such sums from any insurance payment, settlement, judgment, verdict, or other source whatsoever as may be necessary to protect and pay Allegiance Orthopedic and Spine Institute, PLLC the full amount of all sums billed by, due, or to become due Allegiance Orthopedic and Spine Institute, PLLC from or on behalf of the above-named patient (including but not limited to any monies from any tortfeasor, insurance company, or other payor whatsoever). If I received money on the patient's behalf from any source, including money paid in this case, then I agree to hold and preserve sufficient funds to fully satisfy the sums due and owing to Allegiance Orthopedic and Spine Institute, PLLC, or to become due and owing to it according to the terms of this document. If a dispute arises, payout will be made only upon agreement of all parties or court order. I agree that all sums will be due immediately upon being billed by Allegiance Orthopedic and Spine Institute, and must be paid to Allegiance Orthopedic and Spine Institute, PLLC from funds received by me on behalf of the patient, my client, within (10) days from the resolution of the subject litigation relating to my client, or upon my coming into possession of any other funds whatsoever for or on behalf of the patient.*

*In addition, I further agree that any and all charges for medical records duplication, review of records, independent medical evaluations, depositions, conference, expert testimony, and photocopying are not charges payable upon a contingent basis and that I, the patient's attorney, am fully responsible for such charges when I request any such thing/service. These charges are payable to Allegiance Orthopedic and Spine Institute, PLLC regardless of the outcome of the litigation and even if there is no recovery obtained from a third party to pay for these services.*

*I agree to notify Allegiance Orthopedic and Spine Institute, PLLC in writing within (10) days, if the above named patient changes his/her status as my and I am no longer the patient's attorney. Lastly, I agree that any action brought on account of any matter set forth above shall be brought in the Circuit Court in Palm Beach County, Florida as the exclusive venue therefor.*

\_\_\_\_\_  
Attorney Name

\_\_\_\_\_  
Attorney Signature

\_\_\_\_\_  
Date