PATIENT LIEN/ ATTORNEY PROTECTION/ ASSIGNMENT OF BENEFITS AGREEMENT

PatientName:____________________________D.O.B___/___/___Telephone: ____________________

Patient Address: _________________________ Claim Number: ________________________________

Attorney Name: ____

Attorney Telephone#:_______________________________ Fax #:_______________________________

I hereby authorize Portera Rehabilitation to furnish you, may attorney with a full report of the examination, diagnosis, treatment, prognosis, etc.., regarding the above specified accident in which I was involved.

I hereby authorize and direct you, my attorney to pay directly to Portera Rehabilitation such sums as may be due and owing for medical services rendered to me by reasons of this accident. I hereby direct you, my attorney to pay directly to Portera Rehabilitation any bills that are due to Portera Rehabilitation and to withhold such sums from may settlement, judgment, or verdict as may be necessary to adequately protect Portera Rehabilitation. I hereby further give a lien on my case to you, my attorney, or to myself, for treatment by Portera Rehabilitation as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby agree that should I choose to retain different legal representation. I will notify Portera Rehabilitation within ten (10) days of such change. I understand that I will be responsible for ensuring that my new attorney signs this Letter of Protection.

I fully understand that I am directly and fully responsible to Portera Rehabilitation for all medical bills submitted by Portera Rehabilitation for all medical bills submitted by Portera Rehabilitation for services rendered to me. This agreement is made solely for Portera Rehabilitation additional protection and in consideration of Portera Rehabilitation awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or permit for which I may eventually recover a fee. This lien is valid until such time that the amount is paid in full.

Please acknowledge this agreement by signing below and returning to Portera Rehabilitation. Portera Rehabilitation has advised me that by asking them to defer payment by way of this lien they will not be asked to bill Insurance at a later date. I have also been advised that if my attorney does not wish to cooperate in protecting Portera Rehabilitation, Portera Rehabilitation will not defer payment, but will require me to pay on my account and keep it current.

Patient Signature: ____________________________________ **Date:** _____/_____/_____

The undersigned being the attorney on record for the above-named patient, does herby agree to observe all the terms of the above and agrees to withhold such sums form any settlement, judgment, or verdict as may be necessary to adequately protect Portera Rehabilitation's interest.

Attorney Signature: ___________________________________ **Date:** _____/_____/_____

4467 Old Branch Ave. Suite 103 Temple Hills, MD 20748 (P) 301-358-6155 (F) 301-423-1440
4483A Forbes Blvd. Lanham, MD 20706 (P) 240-467-5732 (F) 240-582-5746

IN THE WITNESS WHEREOF, Covered Entity and Business Associate have executed this Business Associate Agreement on the Effective Date.

BUSINESS ASSOCIATE:	**COVERED ENTITY:**
	PORTERA RAHABILITATION
Signature: ____________________________	Signature: _____________________________
Print Name/ Title: ______________________	Print Name/Title: ________________________
Address: _____________________________	Address: _______________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________

Attorney must notify Provider once the claim has settled. VIA phone or fax within 10 Business days.