

**Precision Sports Therapy**  
**Dr. Travis Conley, DC DACBSP**  
4425 Jamboree Rd., #117 Newport Beach, CA 92660  
Phone (949)228-5820  
Email: [info@precisionsportstherapy.com](mailto:info@precisionsportstherapy.com)

**MEDICAL LIEN AGREEMENT**

Patient Name: \_\_\_\_\_

Date of Injury/Incident: \_\_\_\_\_

\_\_\_\_\_ desires medical treatment by **Dr. Travis Conley, DC DACBSP** for injuries sustained in  
(Patient)

the above-referenced accident/incident (“Incident”), and has or shall be retaining \_\_\_\_\_  
(Attorney)

to seek compensation from a potentially liable “third party”. Provider agrees to establish a creditor-debtor relationship by this Agreement, where Provider agrees to treat Patient on a “lien” basis (“Medical Lien”) for the Incident-related injuries. The reason for the Medical Lien is because insurance is not being used to cover Provider’s full fees, Patient indicates that Patient is unable to pay for the full medical bills until the conclusion of treatment (other than any agreed-upon co-pay), and/or Patient and Attorney are confident in obtaining monies from “third party(ies)” or their insurance carrier(s) to compensate Patient and also be sufficient to pay Provider’s Medical Lien.

Provider’s Medical Lien is against any and all proceeds arising from the Incident, including, but not limited to, any settlement, judgment, or verdict which may be paid directly to Patient or to Attorney on behalf of the Patient. In exchange for Provider agreeing to delay being fully paid, unless a state or federal statute or court order provides otherwise, the Parties to this Medical Lien agree to each of the following:

1. That Provider may release all medical information, billing, treatment notes, etc. concerning Patient’s condition and treatment to Patient’s insurance company, attorney or insurance adjuster in connection with the incident.
2. That Provider’s standard fees and charges are reasonable and customary within the accepted range of similar services in the market where Patient is receiving treatment. Patient and Attorney will promptly advise Provider, upon receipt of any billing statement, of any issue or objection to Provider’s fees and charges;
3. That Provider will consider a reduction in Provider’s lien in certain cases upon written request; however, no such reduction is agreed to pre-treatment, and any interlineations to this Medical Lien stating otherwise is not effective unless initialed by Provider at each change to this document. No reduction is deemed accepted without Provider’s signed written consent specifically agreeing to the amount of any discount, and any discount accepted is good for 30 days only; after 30 days the prior reduction agreement is automatically void and not enforceable;
4. That Provider’s lien shall be considered first in priority of repayment among all later-retained medical providers;
5. That Provider’s bill regarding Patient shall be paid promptly, and from the first monies received by or for Patient related to the Incident;
6. That any “medpay”, PIP or similar insurance payment entitlement related to the Incident, paid or to be paid by any insurer for or related to Provider’s bill, is assigned and to be paid directly to Provider, and if sent to Patient or Attorney, that med pay or PIP will promptly sent to Provider. Patient is still responsible for any invoiced amounts med pay or PIP fails to fully cover.
7. That if Patient’s case or lawsuit doesn’t result in a recovery that pays Provider’s bill in full, Patient agrees to remain fully liable for any remaining balance, and to promptly pay personally all remaining monies due and owing;
8. That if Provider’s bill is not promptly paid within ten (10) days of sufficient funds received related to the Incident, then interest on the sums owing Provider shall accrue at the rate of ten percent (10%) per annum, from the date treatment concluded until the outstanding balance is fully paid; and,
9. That if an attorney’s involvement is required 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 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 Orange County, CA.

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, that 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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**PATIENT AGREEMENT:**

Patient agrees to all the above so that Provider will agree to provide medical treatment on a "lien" basis for the incident-related injuries sustained. Should Patient retain new counsel, Patient agrees to provide that new counsel a copy of this Medical Lien prior (to retention, with the new attorney being bound as is Patient's original attorney.

DATE: \_\_\_\_\_

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

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

**ATTORNEY AGREEMENT:**

Attorney agrees to honor all terms and conditions of Patient and Provider's Medical Lien agreement as stated above. Attorney agrees to communicate to Provider in a timely fashion that ongoing progress of the lawsuit, prompt written notification of any change in Attorney's representation of Patient, and prompt written notification of the resolution of the lawsuit in whole or in part. If a new attorney is substituted in, this lien will be transmitted to that new attorney prior to formal substitution, with advisement that the new attorney is bound by this lien by virtue of the original attorney's agreement.

DATE: \_\_\_\_\_

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

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

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

**PROVIDER AGREEMENT:**

Provider, in reliance upon the agreement by both the Patient and Attorney to all the above, agrees to accept and treat, or continue to treat, Patient related to the injuries sustained in this Incident under the conditions stated.

DATE: \_\_\_\_\_

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

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