

# **PATRICK PHYSICAL THERAPY, INC.**

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11845 W. Olympic Blvd. #100  
W. Los Angeles, CA 90064  
Phone: (310) 694-5371  
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## **LIEN AGREEMENT**

I, \_\_\_\_\_ hereby grant a lien to Patrick Physical Therapy, Inc. upon any settlement claim, Judgment claim as a result of an accident, illness occurring on \_\_\_\_\_. I authorize and direct my attorney to pay directly to Patrick Physical Therapy, Inc. any and all sums due to it for services rendered to me and to withhold such sums owed Patrick Physical Therapy, Inc. from any settlement or verdict as may be necessary to adequately protect Patrick Therapy, Inc. Furthermore, I agree that Patrick Physical Therapy, Inc. shall not be responsible and shall not pay any attorneys' fees, expenses or costs for any claim or action I may have or for the collection of any funds due me from any third parties. I agree to have all my attorneys, whether currently retained or retained in the future, execute this document and agree to be bound by the terms contained herein until Patrick Physical Therapy, Inc. has received payment in full.

I fully understand that I am directly responsible for any and all charges submitted by Patrick Physical Therapy, Inc. and that this agreement is for the protection of Patrick Physical Therapy, Inc. and in consideration of its awaiting payment. I also agree that all sums due will accrue interest at 1 1/2% per month until all sums are paid in full. Cancellations with less than 24 hour notice will be billed at \$80 per visit. I agree to pay the reasonable costs and attorneys' fees of Patrick Physical Therapy, Inc. in order for them to collect all sums due them on my account, including any actions against me to collect such sums. If settlement is not reached six (6) months from date of first treatment, payment in full is to be made by the patient, parent, or guardian. Insurance will **NOT** be filed at that time.

I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Attorney's Signature