NOTICE OF DOCTOR'S LIEN

ATTORNEY: _____

ADDRESS: _____

PATIENT: _____

DATE OF INJURY: _____

I do hereby authorize **Daven L. Spencer DC** to furnish you, my attorney, with medical records of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to **Daven L. Spencer DC** such sums as may be due and owing for professional services rendered me both by reason of this accident and by reason of any other bills that are due this office. I authorize you to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect **Daven L. Spencer DC., a**nd I hereby further give a Lien on my case to **Daven L. Spencer DC** against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to **Daven L. Spencer DC** for all professional bills submitted by their office for services rendered me and that this agreement is made solely for their additional protection and in consideration of their awaiting payment. I understand that **Daven L. Spencer DC** may assess interest on my accounts and I agree to pay the interest in addition to the outstanding principal balance. I understand that the total interest to be assessed will not exceed 18% annually. I further understand that such a payment is not contingent on any settlement, judgment of verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning it to **Daven L. Spencer DC.** I have been advised that if my attorney does not wish to cooperate in protecting the interests of this office, **Daven L. Spencer DC** will not await payment but may declare the entire balance due and payable.

DATED: _____ **PATIENTS SIGNATURE:** _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect **Daven L. Spencer DC** for all services rendered to said patient.

DATED: _____ **ATTORNEY'S SIGNATURE:** _____

Please date, sign, copy and return original copy to:

Daven L. Spencer D.C.
239 Drakeside Rd.
Hampton, NH. 03842

Please be sure to keep one copy for your records.