LAUREN CIEL SWERDLOFF MD, INC.
1821 WILSHIRE BLVD. SUITE # 220
SANTA MONICA, CA 90403
(310) 829-5189
FAX: (310) 829-5942

MEDICAL LIEN

Date:_____
To:_____
Address:_____
Date of Injury:_____

I understand that I am indebted to Lauren Swerdloff, MD., A Medical Corporation in connection with payment for medical service rendered to me by this corporation. Furthermore, I understand that this debt is not contingent upon the outcome of my legal case.

This accident and the resultant injuries have caused me to incur substantial debts and other losses. Unfortunately, I am not able to pay all my bills at this time.

I intend to pay for the medical services provided. Therefore, I herby direct my attorney to withhold monies from any settlements, recoveries or other outcomes from legal actions related to the accident that precipitated the medical care provided by Lauren Swerdloff, MD., A Medical Corporation. With in thirty(30) days upon receipt of any settlements, recoveries or other outcomes from said legal actions, my attorney will use such monies to pay you directly for all unpaid balances representing medical services provided to me by Lauren Swerdloff MD., A Medical Corporation.

I do hereby authorize Lauren Swerdloff, MD., A Medical Corporation to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

Client Name:_____
Client Signature:_____

As the Attorney of record I will personally guarantee that medical services by Lauren Swerdloff, MD., A Medical Corporation will be paid before any Attorney's fees are recovered. And in the event of non-recovery I will personally guarantee that my client will pay his debt.

Attorney Name:_____
Attorney Signature:_____
Date Signed:_____