

**TEXAS BACK CARE
Dr. Carl M. Naehritz III, D.C. & ASSOC.
2900 HIGHWAY 121, STE. 120
BEDFORD, TX 76021
(817) 545-1100 FAX (817) 545-1101**

**IRREVOCABLE ASSIGNMENT CLAIM, LIEN CAUSE OF ACTION AND
AGREEMENT**

Re: Medical Reports and Lien for _____,

I do hereby authorize _____, who is my treating doctor and, (hereafter "the treating facility"), to furnish my attorney, and/or the insurance carrier, with a complete report of any medical examination, treatment, prognosis, etc. (including notes, X-rays, and other medical data, as determined necessary by my treating doctor), relating to my health care treatment in regard to the automobile accident or other contributing incident giving rise to my need for such health care services.

ASSIGNMENT OF CONVEYANCE OF LIEN INTEREST AND CAUSE OF ACTION AND AGREEMENT

I hereby execute and provide this **Irrevocable Lien Interest, Cause of Action and Agreement and Assignment of Proceeds** in favor of the above named doctor and/or the doctor's designated treating facility. This **Irrevocable Lien Interest, Cause of Action and Agreement and Assignment of Proceeds** shall apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payments insurance policy to which I am entitled, and from which I am to be paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from the above identified accident (collectively the "insurance proceeds").

The Insurance Carrier is instructed that pursuant to this **Irrevocable Lien Interest, Cause of Action and Agreement and Assignment of Proceeds** the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility.

As consideration for my execution of this **Irrevocable Lien Interest, Cause of Action and Agreement and Assignment of Proceeds** I represent that said doctor and/or treating facility has provided me professional services upon my request, that I am aware of the nature and expense of all such services so provided and that as consideration for his forbearance of his legal right to require payment by me at the time such services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this **Irrevocable Lien Interest, Cause of Action and Agreement and Assignment of Proceeds** shall apply to all insurance proceeds to which I am entitled and direct that the amount of such proceeds required to satisfy my outstanding balance with said doctor and/or treating facility be remitted directly to the doctor and/or treating facility, at such time as I receive an insurance settlement or other monetary settlement/award.

In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s)

I fully understand and stipulate that I am ultimately and directly responsible to the doctor and/or treating facility for all medical bills incurred by me for those services rendered to me, or on my behalf or request, and that this agreement is made solely for the benefit of the doctor and treating facility, as additional protection and in consideration of the treating facility's agreement to forgo immediate collection of payment for such services rendered.

This Lien, Assignment of Benefits, cause of action and agreement and/or Subrogation Interest can not be revoked or modified without the written consent of Dr. Carl M. Naehritz III, D.C.

SIGNED: _____ DATE: _____

Printed Name of Patient: _____

For or On Behalf of the Minor Child: _____, I do hereby assume full financial responsibility.

SIGNED: _____ DATE: _____