RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT:_____

INSURED:_____

DATE OF INJURY:_____

CLAIM NO. / POLICY NO.:_____

SOCIAL SECURITY #:_____

I _____, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician listed below:

Kenneth Best, D.C.
6135 Lindenhurst Ave
Los Angeles, CA 90048
Tel: 323-655-5515
Fax: 323-655-0860

As the owner and/or beneficiary of this policy or claim, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bill for the remainder of this claim.

Thank you for your cooperation in this matter.

_____ _____

Patient/Insured Signature Date

NOTICE OF DOCTOR'S LIEN

Kenneth Best, D.C.
6135 Lindenhurst Ave
Los Angeles, CA 90048
Tel: 323-655-5515 Fax: 323-655-0860

Patient's Name:_____

I do hereby authorize Kenneth Best, D.C. to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was injured on _____ .

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for medical services rendered as a result of this accident, and to withhold such sums from any settlement or judgment as may be necessary to adequately protect said doctor. And I hereby further give a LIEN on my case to said doctor against any and all proceeds (including "medical payments") of my settlement or judgment which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated.

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 must honor this lien as inherent to the settlement and enforceable upon the case as if the subsequent attorney executed it. You will notify said doctor if a new attorney replaces you within 30 days of such substitution of counsel, and you will notify such subsequent attorney, IN WRITING, when the file is transferred, of the existence of this lien agreement.

I expressly authorize and direct my attorney to release information concerning my case, including settlement disbursement, to said medical facility, if for any reason the doctor's lien is not fully and timely satisfied. You are further instructed to return this lien to the doctor promptly, and to complete and return Status Request correspondence, as reasonably required by the doctor, within ten (10) days of your receipt of such Requests.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement or judgment by which I may eventually recover.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance as presently due and payable, and may pursue collection, accordingly.

Patient's Name:_____

Dated:_____ Patient's Signature:_____

The undersigned attorney of record for the above-referenced patient does hereby agree to observe ALL of the foregoing terms, and agrees to withhold such sums from any settlement or judgment as may be necessary to adequately protect said doctor named above. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorneys' fees and costs.

Dated: _____ Attorney's Signature:_____

Please date, sign and return one copy to the doctor's office, also keep one copy for your records.