INSIGHT INSTITUTE OF NEUROSURGERY & NEUROSCIENCE (IINN)

JAWAD A. SHAH M.D. P.C.

*INSIGHT PAIN MANAGEMENT*INSIGHT RADIOLOGISTS PC*INSIGHT PHYSICAL THERAPY & NEURO-REHAB CENTER* INSIGHT ORTHOPEDIC CENTER*INSIGHT HEALING CENTER*INSIGHT NEURAL REPAIR CENTER*INSIGHT HEALTH & FITNESS CENTER*INSIGHT CHIROPRACTIC CENTER* INSIGHT TOXICOLOGY*ATLANTIS DIAGNOSTIC LABORATORIES*INSIGHT WELLNESS CENTER*INSIGHT NEUROPSYCH*ALLIANCE ANESTHESIA*INSIGHT ANESTHESIA*STERLING ANESTHESIA*PRECISION ANESTHESIA*CHARTER ENDOSCOPY CENTER*INTEGRATED HOSPITAL SPECIALISTS PC*

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RE: Lien against judgments/settlements

I, _____ , understand that I am personally responsible for all charges for services provided to me by the physicians and non-physicians of Jawad A. Shah M.D. PC and its associates, Insight Radiologists P.C. referred to as Insight Imaging, Insight Pain Management Center and Insight Physical Therapy & Rehab Center, hereby referred to as IINN. I instruct my attorney to withhold from any and all judgments or settlements monies owed to IINN prior to any distribution of any judgments or settlements to me or other debtors. Any monies owed should be paid directly to IINN. I further grant IINN a Lien against any judgments or settlements, for any and all services from the first date of service, throughout the pendency of my litigation. I further extend this Lien to any settlements or litigation proceeds, including third party actions for payments of services provided by IINN, even if all or part of these services may in theory be covered by a health insurance carrier. It is my understanding, that if at a later time IINN receives duplicate payment from a third party for these services, that IINN will refund the excess to me.

_____ _____

Date Patient Signature

_____ _____

Date Guarantor Signature

I, _____ , attorney for the above named patient, agree to comply with the above instructions.

_____ _____

Date Attorney Signature

Date Received in office:___/___/_____