INSIGHT INSTITUTE OF NEUROSURGERY & NEUROSCIENCE (IINN)

(Southeast Michigan Surgical Hospital DBA Michigan Surgical Hospital DBA Insight Surgical Hospital, Jawad A Shah MD PC, Insight Pain Management, Insight Orthopedic Specialists, Insight Toxicology, Atlantis Diagnostic Laboratories, Precision Anesthesia, Alliance Anesthesia, Sterling Anesthesia, Insight Anesthesia, Insight Radiologists PC, Insight Physical Therapy & Neuro Rehab, Insight Chiropractic, Insight Healing Center, Integrated Hospital Specialists, Precision Surgical Associates, Insight Health & Fitness Center, Insight Wellness Center, Insight Neuropsychology and Behavioral Health, Insight Extended Care, Mid-Michigan Endoscopy Center-Charter Endoscopy Center, Insight Medical Solutions, Associated Surgical Center of Dearborn, Insight Nutritional Services, Insight Residential Rehabilitation Services, Insight Case Management, Insight DBS and Functional Stroke Recovery Center)

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Fax: (810) 213-0263

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 Southeast Michigan Surgical Hospital, Jawad A. Shah M.D. PC and associates, Insight Radiologists P.C referred to as Insight Imaging, Integrated Hospital Specialists, Insight Health and Fitness Center, Precision Surgical Associates PC, Alliance Anesthesia PLLC, Sterling Anesthesia PLLC, Precision Anesthesia PLLC, Insight Anesthesia PLLC, referred to 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 or services provided by IINN, even if all part of these services may in theory be covered by a health insurance carrier. It is my understanding that is at a later time IINN receives duplicate payment from a third party for these services, that IINN will refund the excess to me.

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Date | Patient Signature | Patient Signature (Print)

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Date | Guarantor Signature | Guarantor Signature (Print)

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

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Date | Attorney Signature | Attorney Signature (Print)