PATIENT LIEN / ATTORNEY LETTER OF PROTECTION / ASSIGNMENT OF BENEFITS AGREEMENT PROVIDER:

NEURON CONNECT | 610 EAST BASLEINE ROAD, TEMPE, AZ 85253 | Tel (602) 888-1012 | Fax (602) 926-8333

Patient Full Name: _____

Date of Birth: _____ Date of Injury: _____

Patient Address: _____

Patient Phone: _____ Patient Email: _____

Attorney Name: _____

Attorney Phone: _____ Attorney Fax/Email: _____

Attorney Address: _____

I do hereby authorize and direct the above-named provider to furnish my attorney with all reports, findings, interpretations, impression, diagnosis, etc. of any and all diagnostic studies that you may perform on me, including those studies performed in connection with any accident in which I was involved. I hereby authorize and direct my attorney, who is identified above, as well as any subsequent attorney I may obtain in addition to or replacement of my above identified attorney, to pay directly to the above named provider all amounts that may be due and owing for medical services rendered to me both in connection with the accident in which I was involved and amounts owed by me for services unrelated to the accident. I hereby authorize and direct my attorney (as well as any future attorneys) to withhold from any settlement, judgment, verdict, or other economic recovery I may receive such amounts as are necessary to adequately protect the above-named provider. I understand that, by this agreement, I am giving the above-named provider a lien on any settlement, judgment, verdict, or other economic recovery I may obtain in my case, including any amounts held by my attorney that are payable to me. I I fully understand that, notwithstanding this agreement, I am directly and fully responsible to the above-named provider for all medical bills associated with the services provided to me and this agreement is made solely for additional protection and in consideration of the provider agreeing to awaiting payment. I understand that this agreement tolls any laws that limit the time for the provider to take action to collect amounts I may owe for the services provided and that my obligations to pay the same are not contingent on my receiving any recovery in my case. I further understand and agree this agreement is not a payment arrangement with respect to the satisfaction of my account whatsoever. I do hereby authorize my attorney to communicate with the above-named provider (or provider's assignee) concerning the status of me and my case and direct my attorney to answer all questions that may be asked concerning me or my case. I agree to notify, and hereby direct my attorney to notify, the above-named provider (or provider's assignee) if I change attorney representation. I agree to notify, and hereby direct my attorney to notify, the provider (or provider's assignee) in writing within 2 weeks of the settlement of my case. Further, if my case settles for less than the anticipated amount and/or my attorney determines that it will be impossible to pay provider in full for all medical services rendered, I hereby authorize my attorney to provide to provider (or provider's assignee) a breakdown of the total settlement amount, along with all costs, fees, or other expenses to be paid from the settlement proceeds, to allow provider (and/or provider's assignee) to make an informed decision on whether to accept less than the total charges billed for my services. I had a chance to inquire into the provider's fees and I acknowledge that the provider's charges for its services are fair and reasonable and that the same appropriately reflect the provider's risk of waiting for its payment until my case is resolved. I further acknowledge that this agreement is an agreement that provides collateral for the amounts I owe with respect to the services rendered to me and does not constitute a payment arrangement or other agreement regarding the payment of

any amounts I may owe with respect to services rendered to me. I hereby authorize the provider to assign my account receivable and to provide copies of all my records relating to the assigned portion of my account receivable to the assignee. I understand and agree that any assignee of the provider is entitled to all of the rights and privileges provided to the provider by this agreement. I understand that such an assignment will not affect my obligations or my attorney's obligations under, or the consents I am giving in, this agreement. If there is a controversy or claim (each a "Dispute") arising from or otherwise relating to the terms of this agreement, I hereby consent and agree that such Dispute will be resolved through binding arbitration in the county and state where provider is located, with the American Arbitration Association ("AAA") before a single arbitrator. Such arbitrator shall award attorneys' fees and costs to the prevailing party.

Full Name: _____

Signature: _____ Date: _____

The undersigned being the attorney of record for the above patient does hereby agree to honor the above lien, and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect the above provider.

Attorney: Please sign, date, and return one copy to the healthcare provider. Keep one copy for your own records.

Attorney Full Name: _____

Signature: _____ Date: _____