

DR. ANTHONY F. CALZARETTO
401 COOPERLANDING ROAD SUITE C-17
CHERRY HILL, NJ 08002
PHONE: (856) 667-0505 FAX: (856) 667-8083

ACKNOWLEDGMENT OF DOCTOR'S LIEN AND PATIENT'S RESPONSIBILITY

I do hereby request chiropractic care and treatment from Dr. Anthony Calzaretto for conditions relating to my accident. I fully understand that it is my personal obligation to promptly pay Dr. Anthony F. Calzaretto as said treatment and care is rendered. Dr. Anthony F. Calzaretto has agreed to process my bills with any insurance company that may be deemed responsible for said bills. As such, in consideration of his rendering said treatment and care to me, and in consideration of his submission of bills directly to any responsible insurance carrier I hereby authorize and direct any insurance carrier, attorney, law firm or any other party responsible for the payment of said bills to pay directly to Dr. Calzaretto such sums as may be due and owing him for medical services rendered to both by reason of this accident and by any other reason and to hold such sums from settlement, judgment or verdict as may be necessary to adequately protect said doctor. And, I hereby further give lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict or benefits which may be paid to any third party as a result of injuries for which I have been treated in connection therewith, and/or as a result of benefits due to me through any applicable insurance policy.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and this agreement is made in consideration for said doctor's additional protection and in consideration of his awaiting payment.

I hereby acknowledge and understand that payment is not contingent on a settlement, judgment or verdict associated with any litigation arising in connection with bills generated as a result of services rendered.

I hereby acknowledge and understand that inasmuch as treatment rendered maybe in connection with physical maintenance and/a wellness program, as well as my personal comfort and desires and as much may not be entitled to coverage or otherwise compensable under any insurance policy, I will remain personally liable to Dr. Anthony Calzaretto for any balances not covered or otherwise payable under any insurance policy. As such I acknowledge and understand that my responsibility to pay said balances is not subject to, altered or conditioned by any Arbitrator's decision or Judge's decision regarding any insurer's liability to pay said bills or expenses. And, I acknowledge that decisions by an Arbitrator or Judge regarding medical necessity are not binding upon me nor affect my direct liability to the doctor. As such, this lien shall survive and not be altered by any decision from an Arbitrator or Court.

I hereby assign my right to initiate litigation or otherwise pursue any other means of collections for any outstanding balances to Dr. Anthony F. Calzaretto and I hereby agree to fully cooperate with him or his selected attorneys in the prosecution of claims for payment of his services, agreeing to execute the necessary documents including but not limited to Assignments, Powers of Attorney, appear at Depositions, Examinations and Trials.

I have read the above and confirm the same to be a true and correct representation of my wishes and desires.

I hereby sign this document freely and voluntarily without force or coercion of any type.

X _____
(Patient's Signature)

Date: _____

X _____
(Attorney's Signature)

Date: _____