ATTORNEY MEDICAL LIEN AGREEMENT

I, ____do hereby authorize ***SCAR REVISION LLC.*** to furnish you, ____, my attorney, with a full report of his/her examination, diagnosis, treatment, etc., relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay directly to ***SCAR REVISION LLC*** such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant ***SCAR REVISION LLC*** a lien on my claim against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to the above provider for all professional bills submitted by the provider for services rendered to me and that this agreement is made solely for the providers' additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of **ARIZONA**.

______________________________ ______________________________

Patient Name (Print) Patient Signature Date

______________________________ ______________________________

Patient Number Date of Injury Signature of Parent/Guardian Date

Address________________________City______________ State________Zip________

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed provider and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Attorney agrees to notify the provider immediately the name and contact information of any attorney substituted in his/her place.

______________________________ ______________________________

Attorney Name (Print) Attorney Signature Date

______________________________ ______________________________

Company Name State Bar Number

Company Address ____

STATE OF ARIZONA)

) SS.

COUNTY OF ____________________)

Subscribed and sworn before me this ______day of ______________, 20______________________.

______________________________ ______________________________

My Commission Expires: Notary Public Signature

ATTORNEY(S): Please sign, date, and return one copy to the provider's office and keep one copy for your records