DOCTOR'S LIEN

Gregory J. Hough, D.C.
4771 Trier Road
Fort Wayne, Indiana 46815
Telephone: (260) 492-8300
Fax: (260) 492-8301

______________________________ ______________
Patient's Name Birthdate

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Name of Attorney(s)

I hereby authorize Dr. Gregory J. Hough to disclose to my attorney(s) a full report of the case history, examination, diagnosis, treatment and prognosis of myself in regard to the accident in which I was involved. The purpose of this disclosure is to permit my attorney to provide me with legal services.

- This authorization has no expiration date
- I understand that I have the right to revoke this authorization by sending a written letter to Dr. Gregory Hough, except to the extent that Dr. Gregory Hough has already taken action in reliance upon this authorization.
- I understand that the information disclosed under this authorization may be redisclosed by my attorney(s) and that the privacy of my information is no longer protected by the federal privacy rule once it is disclosed to my attorney(s).
- I understand that I may inspect or copy the information to be disclosed, except in those circumstances when inspection or copying of my information may be lawfully denied under federal law.
- I also understand that I may refuse to sign this authorization, and that Dr. Gregory Hough will not condition treatment on my providing authorization for this disclosure.

I hereby authorize and direct you, my attorney(s), to pay directly to Dr. Gregory Hough such sums as may be due and owing him for professional services, supplies, items, reports, and proceedings rendered to me or on my behalf both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate Dr. Gregory Hough.

I hereby give a lien on my case to Dr. Gregory Hough against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

- I full understand that I am directly and fully responsible to Dr. Gregory Hough for all professional bills submitted by him for services rendered to me and that this agreement is made solely for Dr. Gregory Hough's additional protection and in consideration of pending payment.
- I hereby waive my right to make any objections regarding the enforceability or appropriateness of this agreement. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

______________________________ ______________
Signature of Patient Date

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Printed Name of Patient

ATTORNEY(S): Please sign, date and return this document to the doctor's office named above. Keep a copy for your records. The undersigned being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Dr. Gregory Hough.

______________________________ ______________
Attorney(s) signature Date