SOUTHWEST DIAGNOSTIC CENTERS
OF COLORADO SPRINGS, LLC.

2020 N. Academy Blvd, Suite 155 * Colorado Springs, Colorado 80909
Telephone (719) 380-7210 * Fax (719) 380-7510

NOTICE OF DOCTOR'S LIEN

TO: _____ **RE: _____**

_____ _____
(Patient Name and Date of Injury)

_____

(_____)_____-_____
(Attorney Name, Address and Phone Number)

I do hereby authorize Southwest Diagnostic Centers of Colorado Springs to furnish you, my attorney, with a full report and records regarding my case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to my injury.

I hereby authorize and direct you, my attorney, to pay directly to Southwest Diagnostic Centers of Colorado Springs such sums as may be due and owing for medical services rendered to me by reason of this accident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment, or verdict as may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Southwest Diagnostic Centers of Colorado Springs for all medical bills submitted by said doctor for service rendered to me and that this agreement is made solely for Southwest Diagnostic Centers of Colorado Springs additional protection. I understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to notify Southwest Diagnostic Centers of Colorado Springs of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and returning to Southwest Diagnostic Centers of Colorado Springs. I have been advised that if my attorney does not wish to cooperate in protecting my bill and if no settlement is reached within 2 years of this signed lien, Southwest Diagnostic Centers of Colorado Springs will declare my entire balance due and payable.

_____ _____
Date Patient Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate Southwest Diagnostic Centers of Colorado Springs.

_____ _____
Date Attorney Signature