

## LIEN FOR MEDICAL SERVICES & ACKNOWLEDGEMENT OF THE RIGHT TO ASSIGN

**I. Preamble.** This is an agreement between Patient, Attorney and Patient's medical provider ("Provider"). This agreement concerns the grant of a lien to Provider and an acknowledgment that Provider may assign the lien ("this Agreement"). Provider intends to assign this lien to Key Health Medical Solutions, Inc. ("Assignee").

**II. Grant of Lien for Medical Services.** Patient and Attorney understand that the medical services, supplies and/or treatment Patient is receiving from Provider as part of the ongoing personal injury claim may be billed as a lien as may be authorized by applicable state law and practice. Patient hereby assigns to Provider and Assignee, and grants it and Assignee a lien on the proceeds that may be recovered on Patient's behalf as a result of any judgment, settlement, arbitration, mediation, litigation, award, verdict, or any other collection activities on Patient's personal injury claim, in which Patient is represented by Attorney, in an amount equal to all such sums as may be due Provider for any and all medical treatment or services rendered to Patient. Patient and Attorney acknowledge that Provider may assign and intends to assign the lien and its right to payment to Assignee, and that Assignee may have the exclusive right to collect all amounts due for services by Provider. Attorney agrees to pay Assignee out of any judgment, settlement, arbitration, mediation, litigation, award, verdict, or any other collection activities on Patient's personal injury claim, in which Patient is represented by Attorney, in an amount equal to all such sums as may be due Provider for any and all medical treatment or services rendered to Patient. Patient directs Attorney to pay Assignee out of any judgment, settlement, arbitration, mediation, litigation, award, verdict, or any other collection activities on Patient's personal injury claim, in which Patient is represented by Attorney, in an amount equal to all such sums as may be due Provider for any and all medical treatment or services rendered to Patient.

Patient and Attorney agree that this lien may cover all services Patient receives from Provider. Except for states in which fees are capped by statute, Patient and Attorney hereby waive any right to object to any fees charged by Provider or Assignee that are the subject of this lien based upon a claim that they are unreasonable or excessive. Patient and Attorney hereby waive any right to challenge or object to the amount of any such fees or charges on that basis.

**III. Payment Agreement.** Patient authorizes and directs Attorney to pay Assignee directly for any billings and fees arising out of the medical services, treatment and care arising out of patient's personal injury claim and by reason of any other bills which Patient may owe Provider or Assignee. Patient and Attorney will notify Assignee of any payment received by Patient for medical services from an insurance company or other source, and Patient will instruct his/her attorney to likewise notify Assignee. All payments up to the amount secured by the lien shall be forwarded to Assignee. Assignee's ability to collect any amounts shall be limited to applicable law and practice. Patient acknowledges that the legal settlement may pay all, part, or none of this amount and that Patient is responsible for complete payment. Patient understands that Patient is financially responsible for any amount not paid pursuant to this assignment, as may be authorized by applicable state law and practice.

Attorney hereby agrees to observe all terms stated herein and agrees to withhold such sum payable to Provider or Assignee, from any settlement, judgment or verdict as may be necessary to adequately protect Provider or Assignee. Attorney shall hold in Attorney's Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay Provider or Assignee for services by Provider. Attorney is further directed to pay from Attorney's Client Trust Account to Assignee that amount which is due and owing for those medical services by Provider. Attorney further agrees that in the event Patient secures other counsel in connection with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall inform such new counsel of this Agreement, and will attempt to secure new counsel's consent thereto.

**IV. Representations And Warranties.** Patient acknowledges and understands that Patient has multiple options to fund Patient's medical treatment, including the use of health insurance, government programs and health maintenance organizations. Patient acknowledges that there may be medical providers who would provide the same medical services for a lower cost or for only the costs that the patient would be responsible for under any insurance policy. Patient either (a) does not have insurance (b) Patient's insurance does not cover the medical services covered by this lien, or (c) Patient has decided voluntarily that obtaining the procedure(s) subject of this lien on a lien basis is preferable to Patient, and in Patient's best interest. Patient agrees that Patient shall not request that the Provider or Assignee bill Patient's health insurer or any alternate funding source at any date after executing this Lien.

Patient voluntarily chooses to obtain treatment on a lien basis, and, therefore, will not utilize other forms of funding. Patient shall not submit the medical charges subject to the lien to Patient's health insurance company (if any) for reimbursement or to apply towards Patient's deductible. Provider or Assignee will, therefore, bill Patient for services on a lien basis. Patient acknowledges that it has incurred the amount billed on a lien basis in exchange for Provider's services. Patient and Attorney acknowledge that Provider or Assignee will not be required to and will not bill Patient's health insurance, Workers' Compensation, government or other medical insurance coverage, if any.

Patient acknowledges that Provider may assign this lien without Patient's or Attorney's consent. Patient and Attorney understand that Provider's Assignee (if any) has purchased an account receivable and lien from Provider, Assignee is not a health insurance company, and that no amounts have been paid by an Assignee to Provider on Patient's behalf. This Agreement, including the Arbitration Agreement, shall be binding upon and inure to the benefit of the parties and their respective successors, heirs (in the case of the Patient) and assigns. Patient instructs Attorney to afford the same respects, rights and privileges to Assignee as Attorney would afford to Provider under the terms of this Agreement and to forward any and all payments to Assignee. Patient understands that Patient may terminate this Agreement and lien any time prior to obtaining any medical services from Provider by providing written notice to Provider or Assignee. Assignee's contact information is located at the bottom of page 2. Patient understands and agrees that this Agreement may not be terminated or rescinded by Provider or Assignee except by express written notice by Provider or Assignee.

The waiver by any party of a breach or violation of any provision of this Agreement shall not operate as, or be interpreted to be, a waiver of any later breach of the same or any other provision of this Agreement. If any portion of this Agreement is held to be unenforceable for any reason, the unenforceability of such provision shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms. No verbal agreement concerning the subject matter of this Agreement shall be effective unless reduced to writing and signed by each of the parties. Patient understands that Patient is represented by Attorney and has sought Attorney's counsel on any decision regarding the funding of Patient's medical care or for any questions Patient may have relating thereto. This Agreement may be signed in parts and have the same force and effect as though executed in one document. A photocopy and/or fax copy of the executed Agreement shall have the same force and effect as the original.

**V. Certification, Authorization and Release in Accordance with HIPAA.** Patient and Attorney certify that the information provided herein is correct and complete. Patient understands that, in accordance with the Health Insurance Portability and Privacy Act of 1996 ("HIPAA"), Patient's medical information relating to this personal injury case may be shared to manage and expedite Patient's medical treatment. Patient authorizes Patient's Provider, Assignee, or Attorney to secure, release, and disclose such medical treatment information with companies and individuals as deemed necessary, and further agrees that examinations, diagnoses, medical treatments, films and reports can be shared with necessary parties involved in Patient's case. Patient also permits Provider or Assignee to use such medical information for marketing purposes. Attorney and Patient acknowledge and represent that Attorney has obtained a Release of Medical Information from Patient for purposes of communications regarding Patient's medical information and that Provider or Assignee is covered by said Release.

**VI. Arbitration Agreement. READ THIS PROVISION CAREFULLY AS IT AFFECTS YOUR RIGHT TO A JURY TRIAL.** Patient, Attorney, Provider and Assignee mutually and voluntarily agree to the following.

(1) Any and all disputes, claims or controversies arising out of or in connection with this Agreement or in any way connected to Patient's medical services or the Attorney's relationship with Assignee, no matter how described, pleaded or styled, including claims arising in tort and/or contract, shall be decided exclusively and finally by binding arbitration. All parties hereby **WAIVE THEIR RIGHT TO A JURY TRIAL** by agreeing to binding arbitration. The arbitration hearing shall be conducted at a location within twenty (20) miles of Patient's address, if Patient is a party, or Attorney's address, if Attorney is a party, as specified in this Agreement. If the attorney and Patient are both parties, then the arbitration hearing shall be conducted at a location within twenty (20) miles of Patient's address. The arbitration shall be conducted before the American Arbitration Association (the "AAA"), pursuant to the AAA Commercial Arbitration Rules, available at [www.adr.org](http://www.adr.org) or upon request.

(2) The arbitration shall be conducted by one neutral arbitrator appointed by the AAA. The arbitrator shall have actual experience in and knowledge of the subject matter of this Agreement to the greatest extent practicable, unless both parties agree otherwise. The arbitrator shall have the authority to award any monetary and nonmonetary relief available to either party in an action otherwise prosecuted in court, including injunctive and other provisional relief. Judgment on the arbitration award may be entered by any court of competent jurisdiction. The cost of initiating the arbitration and the arbitrator's compensation (but excluding fees and costs of Patient's counsel, if any) shall be paid by Provider or Assignee.

(3) This arbitration shall be solely between the parties to this Agreement, and no class arbitration or other representative action may be undertaken by the arbitrator, and the arbitrator shall have no power to consolidate or join claims of other parties or persons who may be similarly situated.

(4) The Federal Arbitration Act ("FAA") and related federal law shall govern the interpretation and enforcement of this Paragraph to the fullest extent possible, to the exclusion of all otherwise potentially applicable state law, regardless of the location of the arbitration proceedings or the nature of the disputes or controversies between the parties to this Agreement. The arbitrator shall apply California law consistent with the FAA and related federal law, including applicable statutes of limitations and shall honor claims of privilege recognized at law.

(5) With the exception of subpart (3) above, if any part of this arbitration agreement is deemed to be invalid, unenforceable or illegal, then the balance of this arbitration agreement shall remain in effect and shall be construed in accordance with its terms as if the invalid, unenforceable, illegal or conflicting provision were not contained herein.

(6) Patient may elect to opt out of this arbitration provision by sending written notice to Assignee before 5:00 p.m. Eastern Time on the tenth (10th) calendar day after this Agreement is executed, or such notice shall be of no force and effect. Assignee's contact information appears below. The foregoing time limit shall be strictly construed. Opting out of this arbitration provision shall not terminate the Agreement or otherwise affect in any way any of the other rights and obligations of the parties hereto under the terms of the Agreement. **Patient and Attorney agree that they have read and understand the Arbitration Agreement. Patient and Attorney represent that the preceding statement is true and correct to the best of their knowledge.**

**VII. Attorney's Fees and Expenses.** In the event of any litigation, arbitration or any other action to collect on, enforce or determine the validity of this Agreement or in any way connected to Patient's medical services, the prevailing party in any such action or proceeding shall be entitled to recover reasonable attorney's fees and actual costs, including fees and costs related to any suit, mediation or arbitration proceeding, appeal, bankruptcy proceeding or other proceeding, in such amount as may be determined by any arbitrator or court, whichever is applicable.

**VIII. Patient and Attorney Information.**

By signing this document, Patient and Attorney fully understand all provisions set forth in this Agreement.

Attorney Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Attorney's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Patient/Patients Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Key Account #: \_\_\_\_\_ OR Card Id/Rx Account#: \_\_\_\_\_ Provider(s): **ReCept Healthcare Services, LP**

*(This Lien and Acknowledgement cover the foregoing case and any other legal or administrative action relating to the subject injury or claim.)*

**Please Complete & Return via Fax or Mail to:**

**Fax: (855) 795-4367 / Mail: Key Health Liens / AccidentMeds, 30699 Russell Ranch Rd. Suite 175, Westlake Village, CA 91362**

**Waiver & Acknowledgement of Medical Services on a Lien**

**Medical Provider:** ReCept Healthcare Services, LP

By signing this Agreement, Patient acknowledges and agrees to the following:

Patient **has considered all possible sources of funding** for Patient's medical expenses, including but not limited to, **liability insurance** medical payments, **MedPay, health insurance, HMOs, PPOs, Medicare, Medicaid, TriCare, Champus, VA Insurance**, and payments available through any applicable state "no fault" provisions (collectively "Other Funding Sources").

**Patient voluntarily elects to receive treatment on a lien, and waives use of Other Funding Sources.** Upon thorough review and consideration of the availability of Other Funding Sources, Patient has decided that obtaining medical services on a lien against all judgments, settlements, and settlement agreements rendered or entered into that arise from the illness or the injuries necessitating the medical services is preferable and beneficial to Patient.

**Patient acknowledges that no Other Funding Sources will be billed for these services**, and that Patient will be solely responsible to the extent permitted by law for the Medical Provider's bills and invoices to Medical Provider or its assignees, including Key Health, if they are not covered, in part or in full, by any judgments, settlements, and settlement agreements arising from patient's personal injury claims or lawsuits. **Patient directs Attorney to reimburse Medical Providers** and its assignees, including Key Health **for all medical services received on a lien and provided pursuant to this Agreement out of any and all judgments, settlements, and settlement agreements rendered or entered into that arise from the illness or the injuries necessitating the medical services.**

**Patient has reviewed this Agreement with Patient's attorneys, including the one named above.**

**Patient expressly acknowledges and agrees that Patient is assuming any and all risks** associated with obtaining medical services on a lien and releases Medical Provider and its assignees, including Key Health, their directors, officers, employees, and agents from any and all claims for loss, expense, damage, or liabilities of any kind that Patient may incur as a result of this decision. Patient declares and represents that, by signing this Acknowledgement, it is understood and agreed that Patient relies upon Patient's own judgment, belief and knowledge and that Patient has not been influenced in making this release by any representations made by Medical Provider, its assignees including Key Health, its employees or agents.

**Patient requests and orders Patient's Medical Providers, and its assignees, including Key Health, to not bill any of Patient's Other Funding Sources**, and Patient orders Other Funding Sources to not make any payments to Patient's Medical Providers and their assignees, including Key Health; Patient shall forward this waiver to any Other Funding Sources as Patient deems necessary. Medical Provider and its assignees, including Key Health shall not be required to accept payment from any Other Funding Sources even in the event that Other Funding Sources has contracted with the Patient or the Medical Provider for the payment of Patient's medical bills.

**Medical Provider and its assignees, including Key Health, assume no duty to advise or investigate** Other Funding Sources, even should they obtain such information. **Patient shall have the right to revoke** this waiver by providing written notice to Key Health at the fax number below any time prior to receiving medical services secured by a lien.

**If Patient is a Medicaid beneficiary, Patient acknowledges & agrees that:** Medical Providers have explained and Patient understands that **Medical Providers will not be billing Medicaid** and will instead be recovering directly from Patient based on amounts and settlements paid by liable third parties. Medical Providers have explained, consistent with requirements under state law, that the medical services provided to Patient may be Medicaid-covered services, and that other medical providers may render the service at no cost to the Patient. Patient hereby agrees that Medical Provider and its assignees, including Key Health are entitled to reimbursement from Patient for medical services provided to Patient by the Medical Providers. Patient further acknowledges and agrees that such reimbursement is recovery from the liable third parties for reimbursement owed to Medical Provider and its assignees, including Key Health for medical services rendered to Patient. Patient hereby acknowledges that Medical Providers and its assignees, including Key Health have established their right to payment from any and all settlements or awards from third parties for medical services provided to Patient, and these rights are separate from any amounts claimed and established by Patient from any and all settlements or awards from third parties.

**For Medicaid beneficiaries: Patient is liable to the extent medical services are paid out of proceeds obtained from Patient's personal injury claim or lawsuit.**

**Attorney Name/Firm Name**  \_\_\_\_\_

 \_\_\_\_\_ **Representing Attorney Signature** \_\_\_\_\_ **Today's Date**

**Attorney Acknowledgement and Acceptance**

 \_\_\_\_\_

**Patient or Patient Guardian Name (Print Clearly)** \_\_\_\_\_ \_\_\_\_\_ **Date of Accident**

 \_\_\_\_\_ **Patient or Patient Guardian Signature** \_\_\_\_\_ **Today's Date**

If you have any questions regarding this case, please contact our Case Management Department at (888) 579-5946 Option 2  
**After careful review of this document, please sign and fax this form to (855) 795-4367**