

# RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT: \_\_\_\_\_

INSURED: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

CLAIM# / POLICY#: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician listed below:

**Lynn Kerew, D.C.**  
**Lynn Kerew Chiropractic, A Professional Corporation**  
**PO Box 251736, Los Angeles, CA 90025-9125**  
**Tel: 310-399-0337**  
**Fax: 310-399-3944**

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bill for the remainder of this claim.

Thank you for your cooperation in this matter.

\_\_\_\_\_  
Patient/Insured Signature

\_\_\_\_\_  
Date

Lynn Kerew, D.C.  
Lynn Kerew Chiropractic, A Professional Corporation  
P.O. Box 251736  
Los Angeles, CA. 90025-9125  
TEL: 310.399.0337  
FAX: 310.399.3944

## NOTICE OF DOCTOR'S LIEN

Patient's Name: \_\_\_\_\_

I do hereby authorize Lynn Kerew Chiropractic to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was injured on \_\_\_\_\_

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for medical services rendered as a result of this accident, and to withhold such sums from any settlement or judgment as may be necessary to adequately protect said doctor. And I hereby further give a LIEN on my case to said doctor against any and all proceeds (including "medical payments") of my settlement or judgment which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney must honor this lien as inherent to the settlement and enforceable upon the case as if the subsequent attorney executed it. You will notify said doctor if a new attorney replaces you within 30 days of such substitution of counsel, and you will notify such subsequent attorney, IN WRITING, when the file is transferred, of the existence of this lien agreement.

I expressly authorize and direct my attorney to release information concerning my case, including settlement disbursement, to said medical facility, if for any reason the doctor's lien is not fully and timely satisfied. You are further instructed to return this lien to the doctor promptly, and to complete and return Status Request correspondence, as reasonably required by the doctor, within ten (10) days of your receipt of such Requests.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement or judgment by which I may eventually recover.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance as presently due and payable, and may pursue collection, accordingly.

Patient's Name: \_\_\_\_\_

Dated: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

The undersigned attorney of record for the above-referenced patient does hereby agree to observe ALL of the foregoing terms, and agrees to withhold such sums from any settlement or judgment as may be necessary to adequately protect said doctor named above. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorneys' fees and costs.

Dated: \_\_\_\_\_ Attorney's Signature: \_\_\_\_\_

Please date, sign and return one copy to the doctor's office, also keep one copy for your records.