I hereby authorize and direct my attorney to pay direct to Southeastern Spine, Brain & Joint all sums due and owing for all services rendered by Southeastern Spine, Brain & Joint for any balance thereof, including, but not limited to medical services rendered, reports made or duplicated, depositions given, or time spent as an expert witness in the case. I authorize my attorney to withhold such sums from any insurance settlement, judgment, verdict, or other source as may be necessary to adequately protect Southeastern Spine, Brain & Joint on all funds owed to me from my case by way of insurance payments, judgment, verdict, or other source which may be paid to my attorney or myself.

I fully understand that I am personally and directly fully responsible to Southeastern Spine, Brain & Joint for all medical bills submitted for services rendered to me. I further understand that this agreement is made solely for the additional protection of Southeastern Spine, Brain & Joint and in consideration of Southeastern Spine, Brain & Joint awaiting payment. I understand that nothing herein releases me of the primary responsibility and obligation of paying Southeastern Spine in full for services rendered. I further understand that my obligation of payment is not contingent on any settlement, judgment, or verdict.

I agree to keep Southeastern Spine, Brain & Joint apprised of the name and address of all attorneys who represent me. Notification of any such changes must be made to Southeastern Spine, Brain & Joint within (10) days. I also understand that if my attorney does not wish to cooperate in protecting Southeastern Spine, Brain & Joint. Southeastern Spine, Brain & Joint will not await payment but will require me to pay the account on a current basis.

In the event any dispute arises as to the charge for any services rendered by Southeastern Spine, Brain & Joint. I hereby authorize and direct my attorney to withhold the full sum claimed by Southeastern Spine, Brain & Joint until said time as the matter is settled by compromise or settlement of judgment. I also agree that I shall be responsible for all attorney's fees and cost collection to Southeastern Spine, Brain & Joint.

By my signature below I have read and understand the terms of this agreement or I will request information, as treatment is needed.

Patient Name:_____ Date of Birth: _____ Patient Signature:_____
(Printed Name) Date Signed: _____

The undersigned, being the 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 insurance payment, settlement, judgment, or verdict as may be necessary to adequately protect Southeastern Spine, Brain & Joint. If I receive money paid in this case, then I agree to hold sums due and owing to Southeastern Spine, Brain & Joint. If a dispute arises, payout will be made only upon agreement of all parties or court order. I agree that all sums will be due and payable within thirty (30) days from the resolution of the subject litigation relating to my client.

In addition, I further agree that any and all charges for medical records, review of records, independent medical evaluations, depositions, conferences, expert testimony, and photocopying are not charges payable upon contingent basis and that I am fully responsible for these charges. These charges are paid to Southeastern Spine, Brain & Joint regardless of the outcome of the litigation and even if there is no recovery or obtained from a third party. to pay for these services.

I agree to notify Southeastern Spine, Brain & Joint in writing within ten (10) days, if the above named patient changes his/her status as my client and I am no longer the attorney of record. Lastly, I agree that any action brought on account of any matter set forth above may be brought in the Circuit Court in Hamilton County, Tennessee, and I agree that service of process at any location shall confer jurisdiction on such court.

Attorney Name:_____ Attorney Signature:_____ Date:_____

Please be advised this patient has _____ insurance coverage. We are not in network or covered by any TennCare/Medicaid products. If we are in network/participating with their insurance plan we will file with their insurance carrier, however the applicable copay will be due at time of service since that portion is automatically deducted from our contract allowable payment by the carrier.