THE HILL MEDICAL
CORPORATION

RED ROCK DIAGNOSTICS, LLC

Attorney Firm Information

Firm Name: _____
Contact: _____
Street: _____
City,State,Zip: _____
Phone: _____
Fax: _____

Patient Information

Name: _____
Address: _____
City,State,Zip: _____
Birth Date: _____
Phone No: _____
SSN#: _____

Date of Accident: _____

I do hereby authorize **Red Rock Diagnostics, LLC** to furnish the above attorney and/or insurance carrier with all records regarding the accident/injury for which I am receiving or have received treatment at **Hill Medical Corporation** beginning on _____/ _____/_____. (*Date of Service*)

I hereby authorize and direct you, my attorney and/or insurance carrier, to pay directly to Red Rock Diagnostics, LLC such sums as may be due and owing for services rendered me both 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 which may be paid to you, my attorney, to myself or to another individual on my behalf, and/or by you the insurance carrier, as may be necessary to adequately protect and clear my account at **Red Rock Diagnostics, LLC** for services rendered at **Hill Medical Corporation.** I hereby give a Lien on my case to **Red Rock Diagnostics, LLC** against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself or to another individual on my behalf, and/or by you the insurance carrier, as the result of the injuries for which I have been treated or injuries in connection therewith.

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 honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to Red Rock Diagnostics, LLC for all bills submitted for service rendered me by **Hill Medical Corporation** and that this agreement is made solely for additional protection and in consideration of awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Interest on this lien is 18% per annum, commencing 30 days from the date of payment of settlement, judgment or award relating to services provided by **Hill Medical Corporation** and purchased by **Red Rock Diagnostics, LLC**.

I waive the Statute of Limitation regarding **Red Rock Diagnostics, LLC** right to recover.

It is understood and agreed that a copy of this lien shall have the same force and effect as the original.

Date: _____/_____/_____ ***Patient's* Signature:** _____

The undersigned attorney of record and/or insurance carrier 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 Red Rock Diagnostics, LLC and to disperse such sums as per lien.

Date: _____/_____/_____ ***Attorney's* Signature**: _____

***** Please Sign, date, and return to:

Red Rock Diagnostics, LLC
P.O. Box 26119
Las Vegas, NV 89126
(702) 362-6077
Fax: (702) 362-5132

THE HILL MEDICAL
CORPORATION

Waiver of Private Health Insurance

ATTENTION: WORK RELATED INJURIES ARE NOT TO BE PLACED ON AN ATTORNEY LIEN STATUS, IF YOU ARE RECEIVING CARE FOR A WORK RELATED INJURY, PLEASE NOTIFY THE FRONT OFFICE STAFF BEFORE PROCEEDING.

It is expressly understood by Patient that a potential or actual Assignee relies upon Patient's representation that NO health insurance coverage exists when determining whether to obtain an assignment from the Provider.

Alternatively, Assignee and Provider are relying upon the representation of Patient that they have elected NOT to utilize their health care coverage because:

A. they do not want to pay / or do not have the ability to pay any co-payments,
B. or, they do not want to be required to meet and pay any deductible amounts are due under their health care coverage
C. or, they do not want to run the risk of having health insurance premiums increased for an incident that was not their fault
D. or, they want to use health care providers who may not be within the network of providers available through said health care coverage.

Patient additionally understands that regardless of whether they proceed under health insurance or through this lien, they will be obligated, upon recovery, to pay some measure of consideration for the medical services being provided to them.

Patient further affirmatively represents that no person has stated, recommended, counseled, advised or otherwise suggested that Patient should not utilize any health insurance for treatment to be rendered to Patient. Patient hereby understands that if health insurance information is not presented at the time of service and the Patient's account/account receivable is assigned at some time in the future to an assignee who pays consideration to acquire the account/accounts receivable and assumes financial cost and risks, Patient will not later claim that health insurance should have covered the service provided, nor shall Patient seek a discount from the assignee so as to pay an amount that an insurance payor would have purportedly paid if health insurance information had been initially furnished to Provider, and Assignee shall have the right to collect the full amount of the billed charges.

Patient Signature **Date**

_____ _____

Print Name

_____