

SPORTS MEDICINE AND REHABILITATION THERAPY, INC.

PHYSICAL THERAPY

www.smartphysicaltherapy.com

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READING, MA. 01867-3618
781-944-5246
FAX: 781-944-6686

INSURANCE: _____

Address

DATE OF INJURY: _____

RE: Medical Reports and Physical Therapy Lien.

FOR: _____
Patient name

I do hereby authorize Sports Medicine and Rehabilitation Therapy, Inc. to furnish you, _____ with a full report of evaluation, treatment, prognosis, etc., of myself in regard to the physical therapy which I am receiving as it pertains to a diagnosis of: _____.

I hereby authorize and direct you, _____ to pay directly to Sports Medicine and Rehabilitation Therapy, Inc. such sums as may be due and owing Sports Medicine and Rehabilitation Therapy, Inc., for medical services rendered me both by reason of an accident and/or by reason of any other bills that are due the office of Sports Medicine and Rehabilitation Therapy, Inc. and to withhold such sums from any sums, settlement, judgment or verdict as may be necessary to adequately protect said Physical Therapy Practice. And I hereby further give a lien on my case to Sports Medicine and Rehabilitation Therapy, Inc. any and all proceeds of any settlement sums, judgment or verdict which may be paid to myself as the result of the injuries for which I have been treated or injuries in connection therewith, and/or as it relates to the above diagnosis.

I fully understand that I am directly responsible to Sports Medicine and Rehabilitation Therapy, Inc. for all medical bills submitted by them for service rendered and that this agreement is made solely for said therapists' additional protection and in consideration of them 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 fees, and that a payment on the account is due and payable upon demand.

Dated: Patient's Signature