Name:
Date:

Donald Rose, M.D.
55 E 86th St, #1A, NY, NY 10028

LIEN

AUTHORIZATION FOR PAYMENT OF PHYSICIAN'S FEE BY ATTORNEY(S)

Patient: _____

Address: _____

1. I, was hurt in an accident on _____. I have retained attorney(s)_____ (telephone #_____) to sue those responsible for my injuries for money damages.
2. In consideration of **RYC Orthopaedics, P.C.** services, both past, present and future, I direct my attorneys to deduct and pay any money I may owe **RYC Orthopaedics, P.C.**, from any money payable to me or my heirs, assigns, etc., from my lawsuit. I specifically direct my attorneys to contact **RYC Orthopaedics. P.C.** to determine the exact amount owed him when my case is completed and immediately pay them.
3. If my attorney(s) named above, give my lawsuit to another attorney, either by their own choice or my choice, I direct my attorney(s) named above, not to forward my file to the new attorney(s) until the new attorney(s) has sent the Guarantee signed by the new attorney(s) to **RYC Orthopaedics, P.C.**, by certified mail, return receipt requested.
4. If I, or my attorney(s), receive any money from any source, at any time, on account of my injuries, the amount of money I owe **RYC Orthopaedics, P.C.**, at that time will be immediately paid to him from the money that is received.
5. If I, or my attorney(s), do not follow this Authorization for the payment of **RYC Orthopaedics, P.C.'s** fees, I will be responsible for all reasonable legal fees involved in the collection of any monies due to **RYC Orthopaedics, P.C**. . that are not paid pursuant to this Authorization.
6. This authorization can only be changed by a dated written letter from **Donald Rose, M.D.**

Signature_____**Date**_____**Witness**_____