Patient Name: _____ Patient Date of Birth: _____

PERSONAL INJURY FINANCIAL AGREEMENT

Consensual Agreement/Equitable Lien/Benefit Assignment Contract and Indemnification Agreement

Please read the following very carefully as it concerns your financial responsibility to the Health Care Provider from whom you are about to receive Medical Care from. Please seek legal counsel.

In exchange for providing necessary Medical Care without payment in full at the time services are rendered, I, the undersigned Patient or Legal Guardian of a Minor, hereby agree to establish an Equitable Lien/Benefit Assignment Contract and Indemnification Agreement, hereinafter referred to as "Agreement", with and in favor of **JayMac Chiropractic and/or Jason D. McDonald, DC**, hereinafter referred to as "Provider", by this signed document and pursuant to Arizona state statutes.

I, the undersigned Patient or Legal Guardian of a Minor, do hereby give my permission, or permission for my minor dependent, for Provider and/or their agent, to file, record and serve notice of this Agreement upon myself and all other parties who may be liable to me for damages from an accident which occurred on: _____ and any subsequent claims arising from this accident for which I am about to receive Health Care for.

I understand that a Medical Lien may be filed in Maricopa County, Arizona on behalf of Provider for all ongoing Medical Care expenses accrued in the office and with all involved 1st and 3rd party payers and legal representatives, for all Personal Injury cases to ensure that all my treatments, visits, and expenses are covered by the appropriate entity. After filing, I understand that all entities will receive copies of this Agreement, Medical Lien, and Lien Notification by first class mail as required by state statute. The copy sent to me is for my own records and does not require any response on my part.

I authorize and direct you, my legal representative and/or insurance carrier, to pay directly to Provider from any and all proceeds from any payment(s), settlement(s), judgment(s), award(s), claim(s), or verdict(s) made by me or to me, entered on my behalf, or agreed to by my legal representative, which relate(s) to the aforementioned accident, in such sums necessary to fully compensate Provider from whom I, or my dependents, have received Medical Care. This Agreement shall have priority from the time and date on which said documents are signed, filed, recorded, and served on all involved parties, over any subsequent liens or assignment of my interests in claims arising from this accident.

I understand that I am, and will continue to be, personally responsible for any, and all medical bills presented to me by my Provider, and that this Agreement granting my Provider a lien is made for valuable consideration received by me from my Provider. Provider agrees to await payment for said Medical Care until payment(s), settlement(s), judgment(s), award(s), claim(s), or verdict(s) is/are received and entered or until a reasonable time has passed since said Medical Care was last rendered, whichever occurs first.

I acknowledge that I may not receive any payment(s), settlement(s), judgment(s), award(s), claim(s), or verdict(s) in my favor as a result of my accident and claims or that my personal Medical Insurance policy may deny any claims and I hereby agree that I will still owe my Provider for the Medical Care rendered, and hereby promise to pay my Provider in a timely manner for all Medical Care rendered to me or my dependents. This promise to pay for Medical Care is not contingent upon any payment(s), settlement(s), judgment(s), award(s), claim(s), or verdict(s) which I may receive.

I agree to be responsible for all administrative expenses associated with my care, regardless of insurance company reimbursement(s), settlement(s) or compromise(s). I agree to be responsible for administrative expenses associated with the processing of my claim, but not limited to; lien recording and servicing expenses, collection expenses, or legal expenses incurred by the Provider while attempting to collect on the medical bills relative to this claim should such activity become necessary.

I hereby agree that I shall not submit any medical bills or claims arising out of this lien for payment to any government sponsored health plan including, but not limited to, Medicare, Medicaid, CHAMPUS, CHAMPVA, TRICARE, and AHCCCS unless it is agreed upon by Provider.

I authorize and agree to pay the full amount of the reasonable Medical Care billings from my Provider, for treatment of my, or my dependents, accident-related injuries, without any reduction for any proportional share of my legal fees and costs in obtaining the common fund recovery (the settlement, judgement, or awards as to my third-party claim for my accident injuries from which I am likely to be paid as authorized pursuant to LaBombard v. Samaritan Health Systems 195 Ariz. 543, 991, P 2d 446 (App. 1998), unless agreed upon by my legal representative and my Provider in writing.

I understand that this Lien and Agreement is enforceable under Arizona law pursuant to ARS § 33-931 by creating an Agreement or Personal Contract between me, my legal representative if applicable, and the Provider and such an Agreement provides a guarantee and security for payment of Provider's bills for Medical Care by me and my legal representative.

I authorize my Provider to sign my name to any check written in both our names where such checks are payment for Medical Care for injuries sustained in the aforementioned accident.

I understand that this Agreement, Consensual Agreement, Lien, and Assignment will continue into perpetuity and will remain enforceable and binding if I should decide to change medical provider(s) and/or legal representative(s) in the future.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

By signing below I state that I understand the terms of the Agreement as described above and hereby agree to the terms, promises and conditions of this document, and hereby sign with full intent that I am legally bound to the terms, promises and conditions contained therein. I wish to receive or have my minor child receive Medical Care under these terms. I also intend for these terms to apply to Medical Care received prior to the date of this document for the aforementioned accident.

Date _____ Date _____

_____ _____

Printed Name of Patient *or* Parent/Guardian (if a minor) Signature of Doctor

_____

Signature of Patient *or* Parent/Guardian (if a minor)

_____

Name of Minor Child (if applicable)