THE MINIMALLY INVASIVE HAND INSTITUTE
Dr Jonathan R. Sorelle M.D.
Phone 702-739-(HAND)4263 Fax 877-739-3590

PATIENT:______________________________
DATE OF ACCIDENT:______________

NOTICE OF DOCTOR'S LIEN

I do hereby authorize and direct you, my attorney or insurance company, to pay directly to said doctor such sums as may be due and owing him for medical service rendered to me both by reason of this accident and by reason of any other bills that are due to his office, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or insurance company, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith. And I hereby direct that any and all sums to be paid pursuant to this lien will take priority to any and all payments which I may receive as a result of the subject case and direct my attorney or insurance company to render payment to Minimally Invasive Hand Institute, prior to payment of myself.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his 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. I also direct the appropriate insurance carrier to make available a separate check payable to Minimally Invasive Hand Institute, should Minimally Invasive Hand Institute or an authorized party, make such a request.

I agree to promptly notify said doctor of any charge or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

PLEASE BE ADVISED THAT IF A PATIENT MISSES AN OFFICE APPOINTMENT A CHARGE WILL BE ASSESED FOR 500.00. IF A SURGERY NEEDS TO BE RESCHEDULED A FEE OF 1200.00 WILL BE ASSESED.

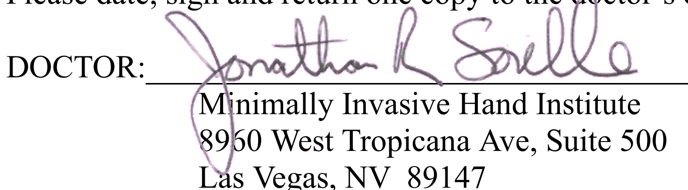
DATED: _______________ PATIENT SIGNATURE: ___________________________

The undersigned 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 settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

DATED: _______________ ATTORNEY SIGNATURE:_________________________

Please date, sign and return one copy to the doctor's office. Also keep one copy for your records.

DOCTOR:__________________________________



Minimally Invasive Hand Institute
8960 West Tropicana Ave, Suite 500
Las Vegas, NV 89147

Nevada Anesthesia Pros.
3524 Moreno Ct
Las Vegas, NV 89129
Phone 702-739-4099 Fax 401-826-8722

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DATE OF ACCIDENT:______________

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