HMP ORTHOPEDICS

50 E. 77th, APT 1C (Left on Main Entrance)
New York, NY 10075

LIEN AGGREMENT

I, ____________________ hereby grant a lien to HMP Orthopedic, PC upon any settlement claim, judgment claim as a result of an accident/illness occurring on ___________, I authorize and direct my attorney to pay directly to HMP Orthopedic, PC any and all sums due to it for services rendered to me and to withhold such sums owed HMP Orthopedic, PC. Furthermore, I agree that HMP Orthopedic, PC shall not be responsible and shall not pay any attorney's fees, expenses or costs for any claim or action I may have or for the collection of any funds due to me from any third parties. I agree to have all mu attorneys, whether currently retained in the future, execute this document and agree to be bound by the terms contained herein until HMP Orthopedic, PC has received payment in full.

I fully understand that I am directly responsible for any and all charges submitted by HMP Orthopedic, PC and that this agreement is for the protection of HMP Orthopedic, PC and in consideration of its awaiting payment. I agree to pay the reasonable cost and attorney's fees of HMP Orthopedic, PC in order to collect all sums due to them on my account, including any action against me to collect such sum.

I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Date: __________ **Patient Signature:** ______________________________

Patient Address: ________________________________

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all the terms of the above agreement and agrees to withhold sum from any settlement or verdict in the patients favor in order to protect the interest of HMP Orthopedic, PC. The undersigned agrees no to release any proceeds of such settlement or verdict to any entity until HMP Orthopedic, PC has been paid in full. The undersigned further agrees to promptly notify HMP Orthopedic, PC of any settlement or verdict regarding the above patient's claim or action and notify any other attorney retained by the above patient of the term of this agreement. The undersigned acknowledges that HMP Orthopedic, PC is not responsible and shall not pay any attorney's fees, expenses or costs in connection with the patient's claim or action.

Date: ____________ **Attorney's Signature:** ________________

HMP Orthopedics, P.C.
Richard E. Pearl, M.D.
50 East 77TH St., Apt 1C
New York, NY 10075

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

I, ______________________________ (Assignor) hereby assign to HMP ORTHOPAEDICS, P.C. RICHARD E. PEARL, M.D.
(Print patient's name) (Print provider's name)
(Assignee) all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on ______________________________ notwithstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the Assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSITS, ABETS, SOLICTIS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

______________________________ X______________________________
PRINT NAME OF PATIENT SIGNATURE OF PATIENT

______________________________ ______________________________
DATE OF SIGNATURE

____
ADDRESS

Richard E. Pearl M.D.
____
SIGNATURE OF PROVIDER

____
DATE OF SIGNATURE

HMP Orthopedics, P.C.
Richard E. Pearl, M.D.
50 East 77TH St., Apt 1C
New York, NY 10075

No Fault Information

Patient Name: ______________________________ DOB: ____________

Telephone: (____) ______-________ Social Security #: ______-______-______

Employer's Name: ______________________________

Address: ______________________________

Contact Person/Manager: ____________________ Phone #: (____) ______-______

Date of injury/accident: ______ / ______ / ______ State where injury occurred: ______

On the date of injury, describe your usual work activities: ______________________________

On that date, what was your job title/description: ______________________________

NO FAULT INSURANCE INFORMATION

Name of Insurance Carrier: ______________________________

Address: ______________________________

Address of where the injury/accident occurred: ______________________________

Contact Person: ____________________ Phone #: (____) ______-______

WCB Case #: ____________________ Carrier Case #: ____________________

Describe how your injury occurred:

____

____

____

Have you lost time from work? ____ No ____ Yes, If yes, how long? ____________

Are you working now? ____ No ____ Yes, Last date worked: ____________

Have you seen another doctor for this injury? ____ No ____ Yes

If yes, please provide his name and phone number?

Physician's Name: ____________________ Phone #: (____) ______-______

Please note: Should the insurance company refuse to accept this claim as a no fault/car accident case, I do understand that I am fully responsible my medical bills at the physician's standard fee.