

**North Suburban Chiropractic and Acupuncture**  
**9464 N. Federal Blvd.**  
**Westminster, Co 80260**  
**PH: 303-427-2225**  
**Fax: 303-430-1158**

HEALTHCARE PROVIDER LIEN

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RE: My Name: \_\_\_\_\_  
Your Insured: \_\_\_\_\_  
Your Claim Number: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_

I HEREBY AGREE to have a lien placed on any settlement, judgment or payment from any legally responsible party or my attorney arising from my injuries related to a legal claim for damages from an incident on or about \_\_\_\_\_, including, but not limited to, a bodily injury liability claim, an uninsured or underinsured motorist claim or any other insurance or legal claim. This lien is for payment of my health care beginning \_\_\_\_\_. I agree to instruct my attorney or other responsible party making payment to pay the healthcare provider listed below for reasonable health care bills from my settlement, Med Pay benefits, or uninsured or underinsured policy. I understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover and I am directly and fully personally responsible to my health care providers for their bills.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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