

IRREVOCABLE ASSIGNMENT, AUTHORIZATION AND LIEN

To whom it may concern:

With this Irrevocable Assignment, Authorization and Lien (this "Assignment"), and in consideration of treatment without having to render concurrent payment I, the undersigned patient, hereby irrevocably transfer set over and assign to Capitol Rehab (the "Health Care Provider") all insurance and/or litigation proceeds to which I am now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the undersigned by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorneys' fees, and I further hereby irrevocably authorize and direct any insurance company and/or attorney to whom and original or copy of this Assignment is provided to withhold from me and pay directly to such Health Care Provider such amount(s) from (1) and insurance benefits payable to me or on my behalf, including, but not limited to, medical payments benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the undersigned, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in my favor may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the undersigned. This Assignment is to be a complete and current transfer of my right, title and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled.

The undersigned patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is to act as a full, immediate and complete assignment of all of the undersigned's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, I hereby irrevocably assign and transfer to the Health Care Provider any and all causes of action that I might have or that might exist in my favor against such insurance company and/or attorney and authorize, and nominate and appoint as my attorney-in-fact any officer, of the Health Care Provider, to prosecute said cause(s) of action either in my name or in the Health Care Provider's name and further I authorize the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

I hereby further give a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the undersigned as a result of the injuries or illness for which I have been treated by said Health Care Provider. The undersigned patient further agrees that the Health Care Provider's statute of limitations on its right to demand payment from the undersigned patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the undersigned patient are ongoing.

Notwithstanding the foregoing, the undersigned patient agrees that until the Health Care Provider is paid in full, the undersigned shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The undersigned further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect of payment, it may demand payments from me immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

I authorize the Health Care Provider to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. I hereby nominate and appoint any officer of the Health Care Provider as my attorney-in-fact to endorse/sign my name on any and all checks for payment of any indebtedness owed by me to the Health Care Provider and to negotiate same for payment of the services provided to me by said Health Care Provider.

Witness my signature and seal as of the indicated date:

Printed Name _____ Date _____ SSN# _____

Signature _____ (SEAL) Witness _____

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The undersigned, being attorney of record for the above patient, does hereby agree to observe all of the terms listed above and agrees to withhold such sums from any settlement, judgment, award or medical payment recovery as may be necessary to adequately protect Capitol Rehab.

Attorney's Signature

Date

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MD: Crofton • VA: Arlington, Annandale, Ashburn, Herndon, Sterling, Winchester • WV: Charles Town