THIS PHYSICIAN PRACTICE LIEN AGREEMENT (the “Agreement”) is hereby entered into by and among:

__________________________(“Patient”),_________________________(“Attorney”) and Erik T Bendiks, MD PC

Patient Name Attorney Name

WHEREAS, Patient was injured in an accident or incident and is seeking medical/diagnostic care from Provider for his/her injuries; and

WHEREAS, Attorney represents Patient in a claim or lawsuit (the “Legal Action”) to recover damages arising from the accident or incident, including medical/diagnostic expenses; and

WHEREAS, Provider has agreed to render treatment to Patient without requiring payment at the time of rendering services;

NOW THEREFORE, in consideration of the premises, the mutual covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Patient acknowledges that, in accordance with the Health Information Portability and Accountability Act of 1996 ("HIPAA"), Patient's medical information relating to the Legal Action may be shared to manage and expedite Patient's medical treatment. Patient authorizes Provider to release any information needed by Attorney to pursue the Legal Action, including without limitation information (including billing information) regarding the examination, treatment, procedures and services rendered by Provider. Patient authorizes Attorney to secure, release, and disclose such medical treatment information with individuals and entities as deemed necessary to pursue the Legal Action, and Patient further agrees that examinations, diagnoses, medical treatments, films and reports can be shared with necessary parties involved in the Legal Action. Attorney acknowledges that Attorney has obtained a Release of Medical Information from Patient for purposes of communications regarding Patient's medical information. Patient expressly authorizes Attorney to keep Provider advised of the progress of the Legal Action at reasonable intervals.
2. Patient hereby grants to Provider a lien on the proceeds of any settlement, judgment or verdict in the Legal Action which may be paid to Patient or to Attorney. Patient hereby notifies Attorney that Patient is giving Provider a lien on these benefits or settlement proceeds, and Patient hereby authorizes and directs Attorney to withhold such funds from any settlement, verdict or judgment that is rendered in the Legal Action and pay Provider directly from any such proceeds any sums due for medical services rendered to Patient. This lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered, unless Provider expressly agrees otherwise in writing. Patient understands that any settlement, verdict or judgment proceeds cannot be disbursed to Patient without first satisfying this lien.
3. Should a dispute arise regarding payment of Provider’s charges, Patient authorizes and directs Attorney to hold in escrow all monies sufficient to satisfy this lien until the dispute can be resolved. Patient and Attorney acknowledge that it would be a violation of Attorney’s ethical duties to disburse the disputed funds prior to resolution of the lien dispute.
4. Patient understands and agrees that even though this lien has been given, Patient remains personally responsible for payment in full of Provider’s fees for all services rendered, including without limitation fees for services provided at Provider’s office locations (e.g., exams and office visits, x-rays, CT, injections, DME, PT, supplies, medicine through Comprehensive Rx or Meds Management Group) and fees for Provider’s services (e.g., surgical services) provided at any other facility. Patient is solely responsible for making appropriate arrangements for payment of such fees, including but not limited to insurance benefits. Patient acknowledges that this obligation to pay Provider’s fees is not dependent on the outcome of Patient’s court case. Provider and Patient agree that in the event it is necessary to enforce this Agreement in a court of law, then in addition to all damages and costs, the prevailing party shall be entitled to reasonable attorney's fees in the amount of 25% of the amount at issue.
5. Provider hereby agrees to await Patient’s payment of Provider’s fees until the Legal Action is resolved by settlement, judgment or verdict, except to the extent that payment is available from Patient’s medical insurance.
6. Patient and Attorney hereby expressly acknowledge the validity and enforceability of Provider’s lien as of the date Provider’s treatment of Patient commences and expressly agree to be bound by the terms of this Agreement. Patient and Attorney expressly acknowledge that this Agreement constitutes actual notice of Provider’s lien pursuant to OCGA §44-14-471(b), and Patient waives the right to assert any defense to the validity and enforceability of Provider’s lien based on Provider’s failure to

perfect the lien in accordance with OCGA §44-14-471(a). Patient hereby directs and authorizes Attorney to provide actual notice of Provider's lien to all parties involved in the Legal Action in accordance with the requirements of OCGA §44-14-471(b), and Attorney agrees to be responsible for providing such notice. The parties agree that a photocopy of this Agreement shall be considered as valid as the original.

7. If Patient should retain new legal counsel, Attorney and Patient agree to notify Provider immediately upon such change. Patient shall direct such new legal counsel to execute another copy of this Agreement and deliver same to Provider.
8. This Agreement cannot be modified, amended or revoked by any party without the express written consent of all parties.
9. If the net recovery is less than the outstanding charges owed to all health care providers covered by letters of protection or lien rights, net settlement proceeds will be distributed on a pro rata basis or as required by legal priority under Georgia or other applicable law.

Acknowledgement by Patient

I acknowledge that this Agreement must be signed by myself and by my attorney before any medical services will be provided to me by Provider. I have been advised that if my attorney does not wish to cooperate in protecting Provider's interest, Provider will await payment and may declare the entire balance due and payable.

____
(Patient's Signature) Date

Patient's Printed Name: ______________________________

____
(Erik T Bendiks, MD Signature) Date

TO PATIENT'S ATTORNEY: ***Please sign, date and return one copy of this Agreement to Georgia Spine and Orthopaedics, LLC. Keep one copy for your records.***

Acknowledgement by Attorney

I acknowledge that this Agreement must be signed by representing attorney and patient before any medical services will be provided to me by Provider. I understand that if I do not wish to cooperate in protecting Provider's interest, Provider will await payment and may declare the entire balance due and payable.

____
(Attorney's Signature) Date

Attorney's Printed Name: ______________________________

____
Attorney's Address (Street, City, State and Zip Code)

GEORGIA SPINE & ORTHOPAEDICS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's name: ______________________________________ Patient's Date of Birth: ___________________
Alternate Name/s: ____________________________________ Patient's ID/Chart No.: ___________________

I, ___________________________________ [patient's name], hereby authorize the use and/or disclosure of my individually-identifiable health information in accordance with the terms set forth below:

1.

I authorize the release of the following information (initial next to each that applies):
_____ All of my medical records (as of the date of this release) that provider has in its possession
_____ All of my medical records, except the following: ____
_____ Only the following: ____

2.

I authorize the following person(s) at Erik Thor Bendiks MD PC, DBA Georgia Spine and Orthopaedics ("GSO") to release the above-indicated records: ____
for the following specific purpose: ____

3.

I authorize the following person(s) to receive the records indicated above:
Any attorney, paralegal, or legal assistant of ____ *Law Firm*
Any representative of ____ *Chiropractic Office*

4.

This authorization automatically expires after one (1) year from the date of execution, or by my express written revocation of same to GSO, whichever occurs first. I further understand that signing this Authorization is completely voluntary, and that my refusal to sign this Authorization will not, in any way, affect the commencement, continuation, or quality of the treatment provided to me by GSO and its medical providers.

5.

I further understand that GSO cannot guarantee that the authorized recipient indicated above will not redisclose this information to a third-party; the third-party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of health information.

6.

I acknowledge receiving an executed copy of this Authorization.
This ____________ day of _________________, 20_______.

___________________________________ ___________________________________
Patient's Name Patient's (or Personal Representative's) Signature

Witness: ___________________________ ___________________________
Printed Name Signature

If a personal representative signed above, provide the following:

Personal representative's name: _________________________

Personal representative's relationship to patient: _______________________

Personal representative's driver's license number: __________________ State: ________________

GEORGIA SPINE
& ORTHOPAEDICS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient ________________________________ Date(s) of Service__________________________

Date of Birth ___________________________________ Social Security (last 4)XXX-XX- _______

I, the undersigned, authorize the release of, or requested access to the information specified below from the medical record(s) of the above-named patient. This information is being released to Georgia Spine & Orthopaedics for purposes of continued medical care.

- o Release all records
- o Release records from the following dates of service: ______________ through ____________
- o Release only the following specific records: ____

  ____

The above information may be released to:

Georgia Spine & Orthopaedics, LLC
Dr. Erik Bendiks and Dr. Jeffrey Dressander
1350 Montreal Road, Ste 290
Tucker, GA 30084
Email: Clinical@GaSpineOrtho.com
Fax: 770.338.6977
Phone: 404.596.5670

FROM:

____

(Doctor, Hospital, Attorney, Insurance Company, Self, Etc.) Phone Number

____

Address (street, City, State and Zip) Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug abuse, mental illness, or communicable disease, including HIV/AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Signature: ____________________________________ Date: ______________________________________

GEORGIA SPINE & ORTHOPAEDICS

New Patient Packet

PERSONAL INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

Home Address:______________________________City:____________________State:________Zip:__________

Home Phone:____________________Cell:____________________Work:____________________ext.__________

Email Address: ______________________________

Social Security: Last 4 XXX-XX-____ Sex: Male / Female Marital Status:____________Work Status: ____________

Employer: ______________________________Occupation:______________________________

Employer Address: ____

Emergency Contact Name: ______________________________Emergency Contact Phone: ____________________

INSURANCE INFORMATION

Primary Insurance: ______________________________Policy Holder: ______________________________

Relationship to Policy Holder: ____________________Policy Holder Date of Birth: ____________________

Secondary Insurance: ______________________________Policy Holder: ______________________________

Relationship to Policy Holder: ____________________Policy Holder Date of Birth: ____________________

MEDICAL INFORMATION CONSENT

I authorize Georgia Spine & Orthopaedics to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Phone Yes/No: ____________________ Cell Phone Yes/No : ____________________

Please list name(s) of person(s) we can discuss your medical care with other than yourself:

Spouse or Significant Other: ____ Yes/No

Parent: ____ Yes/No

Other (relationship): ____ Yes/No

____________PATIENT INITIALS

CONSENT OF TREATMENT

1. I consent to the provision of treatment that may include diagnostic procedures and medical treatment by GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC not to provide such care.

2. I consent to treatment by GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC with the understanding that I will furnish accurate information regarding my injuries and will cooperate when referred to other physicians or medical facilities for examination or testing. My non-compliance with the plan of treatment may result in the refusal of further care and discharge from GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC.

3. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

4. I hereby authorize Georgia Spine & Orthopaedics to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Phone: ________________________ Cell Phone: ______________________ Email: ___________________________

I also authorize the following person(s) access to discuss my medical care unless disclosed or written otherwise.

Name: ________________________________ Phone: ________________________ Relationship: _____________________
Name: ________________________________ Phone: ________________________ Relationship: _____________________
Name: ________________________________ Phone: ________________________ Relationship: _____________________

THE INFORMATION I HAVE PROVIDED IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND ABILITY. I HAVE READ/COMPLETED OR HAVE HAD THIS ACKNOWLEDGEMENT AND CONSENT FORM READ/ COMPLETED FOR ME AND IT HAS BEEN EXPLAINED TO MY SATISFACTION AND APPLIES TOALL ERIKT BENDIKS MD PC PROVIDERS.

____ ____
Patient's Name (printed) **Legal Guardian's Name(printed if applicable)**

____ ____
Signature of Patient (over 18 years of age) or Legal Guardian **Date**

Authorization for Treatment / Assignment of Benefits / Payment Responsibility and Release of Information

Patient Name: __________________________ **Address:** __________________________________

City: ________________________________ **State:** _________________ **Zip:** ___________________

Provider: Georgia Spine and Orthopedics ("GSO")

Authorization for Treatment: The undersigned patient ("Patient") hereby authorizes the healthcare professionals at Georgia Spine and Orthopedics (the "GSO Providers") to render healthcare services to Patient that the GSO Providers deem necessary and advisable. Patient agrees to cooperate with all reasonable requests of the GSO Providers in rendering said services.

Assignment of Benefits: Patient herby assigns and authorizes payment directly to GSO of (i) any private healthcare insurance, (ii) medical payment insurance, (iii) injury benefit due because of liability of a third-party, and (iv) proceeds of all claims resulting from the liability of a third party, payable by any party, organization, attorney, etc., to or for Patient, unless and until Patient's account with GSO for the services or series of related services provided by the GSO Providers (collectively, the "Services") is paid in full, upon discharge or completion of the Services. Patient herby authorizes GSO to apply and file for all such payments referenced herein on behalf of Patient, and direct that such payments be made directly to GSO.

Payment Responsibility: Patient understands that he/she is responsible for any portion of the GSO invoice(s) for Services that remains outstanding. Patient agrees to execute any necessary documents to direct all third party benefits and other payments for Services to GSO.

The undersigned certifies that he/she has read this entire document and is the patient, or the legal representative of the patient, and accepts, agrees, and understands the above agreement and all of its terms.

Patient signature: ____________________________________

Time/Date: ____________________________________

Witness signature: ____________________________________

Time/Date: ____________________________________

FINANCIAL, OFFICE POLICY & HIPPA ACKNOWLEDGEMENT

1. I authorize GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC to bill my insurance carrier and request such payments to be made directly to GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC.
2. I authorize GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.
3. While I understand GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC will attempt to obtain eligibility information, authorizations, and referrals on my behalf, I also understand that it is in my best interest to verify with my insurance carrier what my benefits are and if GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC is participating on my plan. GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC does not guarantee benefits or coverage at the time of service.
4. I understand that any amounts not paid by my insurance are my responsibility and will be paid at the time service.
5. I understand all co-payments and deductibles must be paid at the time of service.
6. I understand, if my account becomes past due, GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC will take necessary steps to collect this debt and my delinquent account will be reported to credit bureaus. If GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC must refer my account to a collection agency, I agree to pay all the collection costs (34% of the past due amount). If a lawsuit is filed to collect on my account, exclusive jurisdiction shall be in the state and federal courts of Fulton County, Georgia. I wave all objections to personal jurisdiction and venue in Fulton County, Georgia. I agree to pay GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC's reasonable attorneys' fees and costs incurred collecting on my account. I acknowledge and agree that the GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC representatives, employees, agents and contractors, including collection firms or attorneys may use my contact information, including my cell phone number to contact me regarding the debt outstanding and any collection efforts.
7. I agree that any claim which may result from the care provided to me by the doctors, physician assistants and other health care providers at either location for GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC facility shall be subject to the laws of Georgia.
8. I also agree that before any lawsuit is filed related to the care provided to me, I must attempt to resolve any claim through mediation. This agreement is binding on me and any person making a claim on my behalf.
9. Notice of privacy practices posted at all practice locations at check in desk.

MEDICAL TREATMENT AND PAYMENT OF CHARGES FOR MINORS:

1. Georgia law requires that a parent or guardian (with written permission of parent) authorize treatment for an unemancipated minor (under age 18). It is that adult's responsibility to ensure payment at the time of service if the minor is not covered by a verifiable insurance plan.

_______________________________ _______________________________

Patients Name(Printed) *Legal Guardian's Name (Printed if applicable)*

_______________________________ _______________________________

Signature of Patient (over18 years of age)or Legal Guardian ***Date***

GEORGIA SPINE
& ORTHOPAEDICS

RELEASE OF INFORMATION FOR PAYMENT PURPOSES

I understand that provided I do not pay for my visit in full at the time of my visit, GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC may release any medical or other information about GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments. I also acknowledge that GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC may release any medical or other information required by my insurer, other payers and their agents. I also authorize GEORGIA SPINE & ORTHOPAEDICS DBA ERIK T BENDIKS MD PC to release medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

_______________________________ _______________________________

Patients Name(Printed) *Legal Guardian's Name (Printed if applicable)*

_______________________________ _______________________________

Signature of Patient (over18 years of age)or Legal Guardian ***Date***

MEDICAL RECORDS

I understand that, by law, my medical record belongs to Erik T. Bendiks MD PC and I have a right to access my records in accordance with state and federal laws. Any requests for copies of paper medical records will be processed within 30 days. You can contact our office at (404) 596-5670.

_______________________________ _______________________________

Patients Name(Printed) *Legal Guardian's Name (Printed if applicable)*

_______________________________ _______________________________

Signature of Patient (over18 years of age)or Legal Guardian ***Date***

HIPAA ACKNOWLEDGEMENT

In accordance with the HIPAA of 1996, I acknowledge that I was given access to and/or offered a copy of the Notice of Privacy Practices for Georgia Spine & Orthopaedics, DBA Erik Thor Bendiks, MD, PC.

_______________________________ _______________________________

Patients Name(Printed) *Legal Guardian's Name (Printed if applicable)*

_______________________________ _______________________________

Signature of Patient (over 18 years of age)or Legal Guardian ***Date***

GEORGIA SPINE
& ORTHOPAEDICS

Financial Agreement

Guarantee of Payment

The information I have provided is true, accurate and complete to the best of my knowledge and ability. I authorize Georgia Spine and Orthopaedics (GSO) to treat me within the scope their specialty and abilities. I further authorize GSO to furnish information which may be required to process and pay claims for service rendered to myself. I authorize my insurance carrier to pay GSO directly for all claims and I reassign such benefits from my insurance carrier to GSO. ***I agree to pay all fees related to my care if payment is not received from my insurance or other sources.*** If a lawsuit is filed to collect on my account, exclusive jurisdiction shall be in the state and federal courts of Fulton County, Georgia. I waive all objections to personal jurisdiction and venue in Fulton County, Georgia. I agree to pay GSO's reasonable attorneys' fees and costs insured collecting on my account. I acknowledge and agree that GSO or its third party collection agencies may use my cell phone and all other phone numbers listed in my account for the purpose of contacting me to collect any debt on my account with GSO.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENTS AND UNDERSTAND MY RESPONSIBILITY:

Signed:

_______________________________ _____________________ ________

Patient/Patient's Representative | Relationship to Patient | Date

1100 Lake Hearn Drive
Ste 360
Atlanta, GA 30342

175 Country Club Drive
Bldg 100 Ste E
Stockbridge, GA 30281

11650 Alpharetta Hwy
Suite 100
Roswell, GA 30076

1350 Montreal Rd E
Ste 290
Tucker, GA 30084

1345 13th St
Ste Q
Columbus, GA 31901

Office: 404.596.5670 *Fax: 770.338.9103* *www.gaspineortho.com*

GEORGIA SPINE
& ORTHOPAEDICS

CLINICAL INFORMATION

Patient Name:____Today's Date: ___________________________

DOB:___________________________Height:_________________________Weight:_________________________

Please state the reason for your visit: ____

____

Is your complaint due to an injury? Yes / No If yes, please answer below to give more detail.

When did the accident/injury occur? ____

Where did the accident/injury occur? ____

Did the accident/injury occur at work? YES / NO

Was the accident/injury the result of an auto accident? YES / NO

If none of the above, please state how the accident/injury occurred: _____________________________________

____

Have you been diagnosed or treated for any of the following problems?

Diabetes	Yes/No	High Blood Pressure	Yes/No
Thyroid	Yes/No	Kidney Disorders	Yes/No
Tuberculosis	Yes/No	Bleeding/Clotting Disorders	Yes/No
High Cholesterol	Yes/No	Deep Vein Thrombosis	Yes/No
Acid Reflux	Yes/No	Peripheral Vascular Disease	Yes/No
Arthritis	Yes/No	Neuropathy/Nerve Disorders	Yes/No
HIV/AIDS	Yes/No	Psychiatric Conditions	Yes/No
Emphysema	Yes/No	Alcohol or Drug Dependency	Yes/No
Hepatitis A/B/C	Yes/No	Chronic Pain Management	Yes/No
Cancer, Type: _____	Yes/No	Asthma Yes/No COPD	Yes/No

List any conditions not listed above: ____

List all CURRENT medications: ____

____

Do you take Aspirin? Yes/No Do you take Fish Oil? Yes/No

Known allergies to Medications/Metals/Latex/ Adhesives? Yes/No ______________________________________

Do you smoke? Yes/No If yes, how many packs per day? _________________________________

Do you chew Tobacco? Yes/No Do you drink Alcohol? Yes/No If yes, how often? ___________________________

List prior surgeries or hospitalizations: (use back if necessary): ____

____

____

____________*PATIENT INITIALS*