

PRESCRIPTION HEADQUARTERS INC.
1340 TULLY RD. #312
SAN JOSE, CA. 95122
PH# (800) 585-4298 FX# (877) 938-0102

AGREEMENT TO REIMBURSE LIEN

PATIENT NAME: _____ DATE OF INJURY: _____
ADDRESS: _____ BODY REGION: _____
CITY/STATE: _____ ZIP _____
TEL: _____ CELL: _____

In consideration of my receiving medication from *Prescription Headquarters* for my injuries arising from my accident of: _____, and pursuant to my Obligation to reimburse *Prescription Headquarters*,

I, _____ DOB: _____
represented by: _____ agree to reimburse *Prescription Headquarters* for all medications incurred for treatment of my injuries from said accident.

I hereby grant *Prescription Headquarters* a lien upon any and all sums recovered by means of settlement, verdict, and judgment on my claim/lawsuit against the parties causing my injuries from the aforementioned accident. I realize that my attorney shall first be paid from my settlement; It is my full intention that *Prescription Headquarters* shall be paid subsequently; after reimbursement for attorney's fees and incurred costs.

The lien for medication from *Prescription Headquarters* shall be paid in full from the remaining sums from the settlement without apportionment or reduction of bills from other medical providers.

I further authorize and direct my attorney to fulfill with the terms of this agreement to reimburse *Prescription Headquarters* from my attorney's trust account the full amount of said lien from any and all sums received from my settlement and consent to a lien. Additionally, if I receive sums directly by means of settlement, and lien is not paid, I agree to personally pay in full the outstanding amount of said lien.

In consideration for the medication I received from *Prescription Headquarters*, I hereby grant this lien and understand that it will become irrevocable on my behalf. Furthermore, I agree to pay all reasonable attorney fees, court costs and/or collection agency fees needed as a result of any delinquent charges outstanding from my medical account at *Prescription Headquarters*.

★ A PHOTOCOPY OF THIS LIEN AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

☒ PATIENT SIGNATURE: _____ DATE: _____

☒ ATTORNEY SIGNATURE: _____ DATE: _____

ATTORNEY NAME: _____	LAW FIRM: _____
ADDRESS: _____	SUITE: _____
CITY _____	STATE _____ ZIP _____
TEL: _____	FAX: _____