ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AUTHORIZATION ("AGREEMENT")
PURSUANT TO VIRGINIA CODE 8.01-66.2-HEALTH CARE PROVIDER LIEN

I hereby direct any and all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/ or other legal entities ("payers", which may elect to be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("conditions"), to pay directly to, and exclusively in the name of Hussey & Lawson Therapies Inc., TA Therapy Direct such sums as may be owing to Hussey & Lawson Therapies Inc., TA Therapy Direct for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges, incurred by me at the office ("charges"). I further grant a contractual lien to Hussey & Lawson Therapies Inc., TA Therapy Direct with respect to my charges, applicable to all payers; however, I understand that nothing in the Agreement shall be construed as an ejection Hussey & Lawson Therapies Inc., TA Therapy Direct to claim protections under any situation lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to proceed from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, workers benefits, worker's benefits, medical payment benefits, personal compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges not.

I further agree that, in the even a payer refuses to pay Hussey & Lawson Therapies Inc, TA Therapy Direct I hereby assign to the office, insofar as permitted by law, the following: all rights, remedies and benefits to Hussey & Lawson Therapies Inc., TA Therapy Direct, as well as any and all causes of action that I might have against such payer to extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent to this office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds of the Office upon its request.

I here by direct all payers to release to Hussey & Lawson Therapies Inc., TA Therapy Direct any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office t release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement, I hereby direct this Office to file a copy of this Agreement together with any applicable charges, with any of all payers, regardless of whether a claim has been established with said payers. I hereby authorize Hussey & Lawson Therapies Inc., TA Therapy Direct to endorse/ sign name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse or any of my departments, I further authorize Hussey & Lawson Therapies Inc., TA Therapy Direct to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition. I understand that I remain responsible for the total amount due Hussey & Lawson Therapies Inc., TA Therapy Direct for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment

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ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AUTHORIZATION ("AGREEMENT")
PURSUANT TO VIRGINIA CODE 8.01-66.2-HEALTH CARE PROVIDER LIEN

and will reimburse Hussey & Lawson Therapies Inc., TA Therapy Direct for all costs such collections efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Hussey & Lawson Therapies Inc., TA Therapy Direct and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with these terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Hussey & Lawson Therapies Inc., TA Therapy Direct and myself. However, should any provision of this Agreement be found to the invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall nevertheless, remain in full force and effect.

PATIENT NAME: (PLEASE PRINT)	PATIENT SIGNATURE	DATE
_____	_____	_____

Name of Custodial Parent or Legal Guardian:

Guardian Print Name:	Guardian Signature	Date
_____	_____	_____

Therapy Direct Personnel Witness/ Receiving Lien Agreement	Date
_____	_____

Hussey & Lawson Therapies Inc., TAX ID# 26-2043376

Please provide us with your attorney/ case information:

Attorney Name:_____

Phone Number:_____

Address:_____

Case#/ Claim#:_____

Third Party Payer (State Farm, Medpay, etc)_____

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