

**ASSIGNMENT OF INTEREST IN PROCEEDS
FROM CLAIM OR LAWSUIT**

STATE OF LOUISIANA
PARISH OF _____

In consideration of services rendered and to be rendered on my behalf by DMA PPO, and its affiliated health care providers, as recommended by my treating physician, and as authorized for and on my behalf through DMA PPO by my attorney, _____, I do hereby irrevocably assign, convey and transfer unto DMA PPO a vested interest in the proceeds of any judgment or settlement in the lawsuit or claim which I am prosecuting to recover damages for my injuries, said vested interest to be sufficient to reimburse DMA PPO to the fullest extent of DMA PPO's Provider's Billed Charges, but in no event less than the sum paid by DMA PPO on my behalf for the cost of all services. This assignment is being made voluntarily in consideration of DMA PPO's provision of the necessary medical care requested, as recommended by my treating physician. This assignment of interest shall be not only for any and all necessary medical care as presently ordered by my attending physician, but for any future said necessary medical procedure as ordered by my attending physician, and for which DMA PPO renders its services.

I do further hereby authorize and empower my attorney, _____, or any subsequent attorney, to deduct immediately from the proceeds of any settlement or judgment, any and all amounts due and owing to DMA PPO for services in accordance with DMA's Provider's Billed Charges, without further authorization from me, and to forward these payments directly to DMA PPO. This authorization is complete and irrevocable, in consideration of the services rendered by DMA PPO.

I do further hereby state that injuries pertaining to my lawsuit or claim are in conjunction with a personal injury case, or a third party tort action involving a workers compensation case; and furthermore, my lawsuit or claim is not in anyway connected with a workers compensation case other than the above exception.

I do further acknowledge that in the event I should change attorneys handling this claim or lawsuit, it is my responsibility to notify said new attorney of my obligation to DMA PPO and to provide them with copies of any and all documentation as may be necessary to protect the interest of DMA PPO and further authorize DMA PPO to enter the date(s) services have been provided to me.

In order to further protect the interest of DMA PPO in this assignment, I am providing the following information concerning my claim or lawsuit, which is true and correct to the best of my knowledge.

DATE OF ACCIDENT: _____

NAMES(s) OF ALLEGED LIABLE PARTY OR PARTIES: _____

NAME OF COURT: _____

CAPTION OF LAWSUIT: _____

CASE NUMBER: _____ SECTION DIVISION: _____

NAME OF INSURANCE COMPANIES PROVIDING COVERAGE: _____

ATTENDING PHYSICIAN: _____

DATE: _____ (CLIENT)

DATE: _____ (ATTORNEY)

ASSIGNMENT OF BENEFITS

In consideration of professional medical services rendered and/or to be rendered by DMA PPO (including its affiliated health care providers together simply referred to as "DMA"), as recommended by my treating physician, and as authorized for and on my behalf through DMA by my attorney, _____, I do hereby irrevocably assign, convey and transfer to DMA a vested interest in the proceeds of any payment by any private insurance or any other third party payor, to the extent sufficient to reimburse DMA for all costs of all services provided to me through DMA at the Billed Charges for such medical services.

This Assignment is being made in consideration of services rendered by DMA in assisting me to obtain necessary medical care I have requested and as recommended by my treating physician. This Assignment of Benefits shall be not be limited to my present medical care, but shall also extend to any future medical procedure ordered by my attending physician, and for which DMA renders its services.

I further authorize and empower my physician, _____, and/or any and all subsequent physician(s), to immediately forward the proceeds of any private insurance payment or third party payment, from any source whatsoever to DMA, without further authorization from me, and to remit such payments directly to DMA. This authorization is complete and irrevocable in consideration of the services rendered by DMA.

I understand that DMA is paying for certain medical services my physician has determined are medically necessary. I further understand that DMA is in the business of contracting with healthcare providers at discounted rates. I understand and agree that I will pay DMA the full Billed Charges of DMA's healthcare providers and that the difference between what I pay DMA and what DMA pays its providers is DMA's income.

In order to further protect the interest of DMA in this Assignment, I am providing the following information concerning my claim or lawsuit, which is true and correct to the best of my knowledge, information and belief.

NAME OF INSURANCE COMPANY(IES) OR THIRD PARTY(IES) PROVIDING COVERAGE:

ATTENDING PHYSICIAN: _____

DATE: _____

(PATIENT/CLIENT)

DATE: _____

(ATTORNEY)

DMA Authorization for Release of Health Information for Billing and Payment

Patient Name: _____
Patient Address: _____
Patient Social Security #: _____
Phone #: _____ Date of Birth: _____

1. The patient's health information may be disclosed to Diagnostic Management Affiliates, L.L.C. ("DMA") or Diagnostic Management Affiliates – Preferred Provider Organization, L.L.C. ("DMA-PPO"), (hereafter referred to as DMA) and to the attorneys for the patient who have been identified by the patient as his/her attorney or who have a written engagement agreement to provide legal services to the patient in connection with a personal injury claim of the patient. The information disclosed may include the patient's health information and may include but is not limited to medical records, billing records, reports, opinions, X-rays, abstracts or excerpts or any records, lab reports, discharge summaries, history and physicals, consults, out patient reports, pathology reports, physical therapy information and reports and emergency records and reports. The information released may include information related to alcohol and drug abuse psychiatric, HIV and/or genetic information.

2. This protected health information is being used or disclosed in order to process and pay medical bills incurred by the patient.

3. This authorization shall be in force and effect until:
All of the patients medical bills incurred in connection with a personal injury for which a claim has been made have been paid. At which time this authorization to use or disclose this protected health information expires.

4. I have the right to revoke this authorization, in writing, at any time by sending written notification to DMA.

5. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

6. I understand that a revocation is not effective to the extent that DMA has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

7. My signature is an acknowledgement that I have received a copy of this authorization.

Signature of Patient or Legal Representative Date: _____

LAW OFFICE OF
KEITH L. MAGNESS
A LIMITED LIABILITY COMPANY
901 DERBIGNY STREET
GRETNA, LOUISIANA 70053
ATTORNEY AT LAW - NOTARY PUBLIC

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Our File: _____

**ACKNOWLEDGEMENT OF DISCLOSURE OF
FINANCIAL ARRANGEMENTS/SERVICE CHARGES**

In consideration of services rendered and to be rendered on my behalf by DMA-PPO, L.L.C. ("DMA") and its affiliated health care providers, as recommended by my treating physician, and as authorized by my attorney, I do hereby acknowledge notification that healthcare providers enrolled with DMA have agreed to discount their Billed Charges for healthcare services provided to DMA members, that the benefit to me of these discounts is indirect because I will be paying the Billed Charge and of the following financial arrangements including disclosure of service charges which I will bear at the conclusion of my case out of any settlement and/or judgment obtained on my behalf:

Diagnostic Testing:

Any charges for covered services not paid in full by the end of the month that is one (1) year from the date the services were provided shall incur a monthly service charge of 1.5% per month (18% per annum, simple interest) until paid in full. Payment in full of the obligation is due by either the date proceeds are received from the settlement and/or judgment of the claim or lawsuit, or 24 months from the date of the service, whichever first occurs.

Surgical Procedures:

Any charges for covered services not paid in full by the end of the month that is one (1) year from the date the services were provided shall incur a monthly service charge of 1.25% per month (15% per annum, simple interest) until paid in full. Payment in full of the obligation is due by either the date proceeds are received from the settlement and/or judgment of the claim or lawsuit, or 24 months from the date of the service, whichever first occurs.

I do hereby authorize and empower my attorney or any subsequent attorney, to deduct immediately from the proceeds of any settlement and/or judgment, any all amounts that are due and owing to DMA, including service charges, without further authorization from me, and to forward these payments directly to DMA. I acknowledge that DMA as a PPO arranges with medical providers to receive discounts based on volume and early payment and will pay an amount lower than the Billed Charges to which I am being charged. This authorization is complete and irrevocable, in consideration of the services rendered by DMA.

I do further hereby state that injuries pertaining to my lawsuit or claim are in conjunction with a personal injury case, or a third party tort action involving a workers compensation case; and furthermore, my lawsuit or claim is not in any way connected with a workers compensation case other than the above exception.

Date

Client's Signature

ADDENDUM A

COVERED SERVICES

*Other services may be available upon request.

Surgery Procedures

Anterior Cervical Fusion and Discectomy

Anterior Lumbar Interbody Fusion

Carpal Tunnel Release

IDET

Laser Percutaneous Discectomy

Medial Branch Neurotomy

Microsurgical Disc Excision

Nerve Blocks and Epidural Injections

Orthopedic Arthroscopy

Posterior Lumbar Fusion

Posterior Lumbar Laminectomy and Discectomy

Threaded Cage Fusion

Testing Procedures

3D CT Scan Bone

Scan

CT Scan (Computed Tomography Imaging)

Discogram

EEG (Electroencephalography)

EMG (Electromyography)

ESI (Epidural Steroid Injection)

Facet Block

Mammogram

MRI (Magnetic Resonance Imaging)

Myelogram

NCV (Nerve Conduction Velocity)

PET Scan (Positron Emission Tomography)

Physical Therapy

Rhizotomy

Sleep Studies

SSEP (Somatosensory Dermatome Evoked Potentials)

Ultrasound

X-ray