CornerStone Family Chiropractic

Dr. Michelle Goldych

P.O. Box 1890 (8212 Brewerton Road), Cicero, New York 13039
Phone: 315-699-1441 Fax: 315-699-2596
www.mgoldych@gmail.com

PATIENT NAME: _____

SOCIAL SECURITY #: _____

CARRIER/CARRIER CASE: _____

DATE OF INJURY: _____

MEDICAL LIEN

I understand I am fully responsible to Dr. Michelle Goldych, D.C. for all medical bills submitted by him for services rendered to me, and any medical bills due and owing will be paid. This agreement is made solely for Dr. Goldych's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I agree to never rescind this document and that a rescission will not be honored by any attorney representing me.

I hereby authorize Dr. Michelle C Goldych, D.C. to furnish any attorney representing me with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved on the above date.

Patient Signature: _____

Date: _____