To: _____ Automobile Insurance Company

Attention: _____ Claim Representative

Claim Number: _____ FAX ( )_____- _____

Written Direction, Assignment of Benefits, Release of Information and Authority to Act on My Behalf for my PIP Benefits

Date of Accident: _____ Todays Date: _____

Dear Sir or Madam:

_____(patient) is obtaining medical imaging services today from Neurodiagnostics, Inc, d/b/a Lexington Diagnostic Center (LDC) and was referred for these services because of injuries in an automobile accident on the date listed above.

As of this date and prior to obtaining these services, I, _____ (patient or parent/legal guardian of patient), hereby direct the reparation obligor (the insurance company responsible for the patient's personal injury protection (PIP) benefits), _____ to pay LDC for today's services, pursuant to KRS 304.29-241. I further request that you reserve enough of the PIP medical benefits to pay LDC for today's charges. I direct you to pay this bill before executing any future direction notices from me.

I further direct that you pay this bill within 30 days of receipt as required by law. If payment is delayed, I direct that you pay the legally required 12 or 18% interest directly to LDC. If for any reason you do not pay for these medical services and/or interest due, I give LDC full authority to act as my agent and/or on my behalf in filing a legal claim in the appropriate court and/or filing a complaint with the Kentucky Department of Insurance. I irrevocably assign LDC, its successors and assigns, medical benefits payable to me (or to the patient) from my PIP funds for today's services.

I further direct that you provide to LDC any and all protected medical records relating to my (or the patient's) case that will assist LDC in collecting payments from you or evaluating any denials, including but not limited to "Peer Reviews", "Second Opinions" or other external reviews. I also authorize you to provide to LDC my (or the patient's) PIP worksheet detailing payments made on my behalf. Please expect a bill from LDC soon for today's medical services.

I authorize a Facsimile (FAX) of this letter to serve as the original.

_____

Printed Name of Patient or Patient's Representative

_____ Date: _____

Signature of Patient or Patient's Representative

_____

Witness

This Letter of Direction Notice has been faxed to the above addressed Claim Representative at ____: ____ AM/PM on _____ 20 ___. Faxed by: _____

Authorization & Lien Agreement

TO: Neurodiagnostics, Inc. d/b/a Lexington Diagnostic Center

I, _____, hereby authorize Neurodiagnostics Inc. d/b/a Lexington Diagnostic Center (LDC) to use and/or disclose my protected health information described below to the person or law firm named below for the following purpose:

Name of Attorney or Law Firm:	**Purpose:**
_____	To authorize a lien against a future settlement or judgment.

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

□ Any and all records in the possession of LDC including mental health, HIV, and/or substance abuse record.
(Cross out any item you do not authorize to be released).

□ Records regarding treatment for the following condition, illness or injury,
_____
on or about_____.

I also understand that I may revoke this authorization at any time, except to the extent that the practice has already released these records. I understand that the lien is not revocable once the test has been performed.

I understand that I do not have to sign this authorization and that LDC may not condition treatment or payment on whether I sign this authorization. However, other payment arrangements will need to be made if you choose not to sign this authorization and lien.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

I hereby give a lien to Neurodiagnostics Inc. on any settlement, claim, judgment, or verdict, as a result of injuries occurred in said accident or as a result of any condition or illness for which I sought LDC services, and authorize and direct my attorney to pay directly to Neurodiagnostics Inc. such sums as may be due owing Neurodiagnostics Inc. for service rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect Neurodiagnostics Inc. adequately.

I fully understand that I am directly and fully responsible to Neurodiagnostics Inc. for all bills submitted for services rendered to me, and that this agreement is made solely for the additional protection of Neurodiagnostics inc. and in consideration of their awaiting delayed payment for services. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I understand that I may revoke this authorization at any time by writing to:

Lexington Diagnostic Center
ATTN: Administrator
1725 Harrodsburg Rd., Suite 100
Lexington, KY 40504

except that any revocation by me shall not have any effect to the extent that the practice has already released these records.

I certify that I have received a copy of this lien and authorization.

Payment discount rates: If the charge amount is received within 90 days of the date of service, I may take a 20% discount.
If the charge amount is received within 6 months of the date of service, I may take a 10% discount.
No discounts will be considered after 6 months from the date of service.

_____ _____
Printed Name of patient or patient's representative Date

_____ _____
Signature of patient or patient's representative Relationship of representative to patient

The undersigned, being attorney of record for the above patient, does hereby acknowledge receipt of the above lien and does agree to honor the same to adequately protect Neurodiagnostics Inc.

Date: _____ _____ Attorney of Record: _____

Attorney's Signature: _____

Address: _____ Attorney's Phone #: _____

City, State, Zip: _____ Attorney Fax #: _____