

*Preferred Compounding Pharmacy, Inc.*

17547 Chatsworth St.  
Granada Hills, CA 91344

Tel: (818) 360-5004  
Fax: (818) 360-5005

Attorney's Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone No \_\_\_\_\_ Fax No \_\_\_\_\_

**Re: Notice of Preferred Compounding Pharmacy, Inc. Lien**

**PATIENT NAME:** \_\_\_\_\_ **PHONE #** \_\_\_\_\_  
**DATE OF INJURY:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

I, the above named patient authorize the above Pharmacy, Preferred Compounding Pharmacy, Inc., to furnish you, my attorney, with full Pharmacy services, dispensing, etc., of myself in regard to the accident in which I was recently involved.

Patient hereby authorizes and directs his/her attorney or insurance company to pay directly to Preferred Compounding Pharmacy, Inc. such sums as may be due and owing for Preferred Compounding Pharmacy, Inc. services rendered to me both by reason of this accident and by reason of any other bills that are due to and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said Pharmacy. And I hereby further give a Lien on my case to said Preferred Compounding Pharmacy against any and all proceeds of my settlement, judgment or verdict which may be paid to you my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

This agreement is in no way relieves patient of his/her responsibility to compensate Preferred Compounding Pharmacy, Inc. for all Pharmacy service bills submitted by said Pharmacy for services rendered to patient. Patient understands and acknowledges he/she is directly and fully responsible to Preferred Compounding Pharmacy, Inc., for any account balance, which is not contingent on the results of any third party claim. Preferred Compounding Pharmacy, Inc. reserves the right to require regular payments on patient's account until his/her third party claim is resolved.

Patient directs his/her attorney to promptly pay the full amount due to Preferred Compounding Pharmacy, Inc., upon resolution of his/her claim with any third party. Payment shall be tendered without regard to set off unresolved claims against other third parties or apportionment or pro-rata distribution to other health care providers.

Patient agrees to promptly notify said pharmacy of any change or addition of attorney(s) used by patient in connection with this accident, and patient instructs their attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I, the patient, have been advised that if my attorney does not wish to cooperate in protecting the pharmacy's interest, the pharmacy will not await payment but may declare the entire balance due and payable.

I have read and fully understand this Preferred Compounding Pharmacy, Inc. Lien and agree to be bound by its terms.

X \_\_\_\_\_ Date: \_\_\_\_\_  
**Patient's signature**

X \_\_\_\_\_ Date: \_\_\_\_\_  
**Guardian's Signature** **Print Name**

Attorney agrees to observe all the terms and conditions of this Health Care Lien and withhold from any third party, without deduction of any attorney's fees, an amount necessary to pay the outstanding account balance to Preferred Compounding Pharmacy, Inc. Attorney agrees to promptly notify Preferred Compounding Pharmacy, Inc. in the event legal representation is terminated. Attorney agrees to promptly provide a copy of this Health Care lien to any additional or subsequent attorneys. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

**Date:** \_\_\_\_\_ **Attorney's Signature** \_\_\_\_\_

PLEASE SIGN, DATE AND RETURN ONE COPY AS SOON AS POSSIBLE AND KEEP ONE COPY FOR YOUR RECORDS.  
THANK YOU

**Copies or photocopies of this "Pharmacy's Lien" will be considered as valid as the originals**