SOZO
Health & Physical Therapy

Dear Patient,

It has become standard practice in the health care industry and a requirement of the State of Arizona per Statute 33-931 and 33-932 to file what is known as a "Notice and Claim of Health Care Provider Lien".

These liens must be recorded with the County Recorder's Office, by law. A copy will be sent to you by certified mail for your records, and will be released when we receive payment in full. A copy of the release will also be sent to you via first class mail. Please be assured that this is not a lien against you, or property.

This is not a reflection on your integrity and will not be picked up by credit reporting agencies for any reason, as this lien is not against you, the patient, but merely a lien for payment from the responsible insurance company for your medical care costs.

We reserve the right to put your entire case on a lien and not bill your personal health insurance. This is typical for in-network plans.

If we bill insurance (in-network) we will not file a lien, which means you will be responsible for any copayments, deductibles, and coinsurances at the time of services provided. On the contrary, if a lien is filed, we will not collect any out of pocket responsibility until the case is settled or negotiated by your attorney.

If all the information on the lien form is not provided by the second visit, we will hold treatment until it is received.

Please be advised that the fees charged for the filing and release of the lien (approximately $75) will be included in the final bill.

At the time of settlement of your case you will receive a check/draft made out jointly to you and the provider, at which time you are required to promptly bring the check/draft to our office for disbursement or endorsement of funds.

If you have an attorney, the check will be made out to you and your attorney. Your attorney must sign an indemnifying agreement with the insurance company to pay any and all liens in full (we rarely negotiate or reduce our fees). If for some reason your settlement does not cover the cost of your care, you are personally responsible and agree to pay the balance of the bill in full.

By signing this notice you understand and agree to the above terms.

Patient's Signature: _____ Date: _____