GENERAL AUTHORIZATION AND ASSIGNMENT OF LIEN

ATTORNEY NAME: ____

PATIENT NAME: ____

PATIENT DATE OF BIRTH: ________________________ TELEPHONE #:_______________________

PATIENT ADDRESS: ____

PATIENT DATE OF LOSS: _________________________ TODAY's DATE:______________________

I do hereby authorize Rapid Rx, LLC, and Las Vegus Community Pharmacy, Inc., herein after referred to as "Pharmacy", to furnish my attorney, with full records and logs of the medication provided to myself in connection with the accident that I was involved in on the above date.

Additionally, I hereby give Pharmacy, and authorize and direct my attorney, to directly pay Pharmacy such sums as may be due and owing them for services rendered to me for reason of this loss, by withholding such sums on any settlement, claim, judgement, or verdict because of my loss to adequately protect said Pharmacy. I agree never to rescind this document and that a rescission will not be honored by my attorney. I instruct that in the event another attorney is substituted in this matter, the new attorney must honor this lien, and is deemed upon notice, as inherent to the settlement and enforceable upon the case and the recovery, as if it were executed by my new attorney.

I, the patient, fully understand that I am directly responsible for payment to Pharmacy for all medications provided to me and I acknowledge that fees of the above Pharmacy are not contingent on any settlement, claim, judgement, or verdict, and that this agreement is made solely for said Pharmacy's additional protection and in consideration for the Pharmacy awaiting payment. I further agree that if this lien is not honored by my attorney, I will make the payments necessary to keep my account current.

Please acknowledge this letter by signing below and returning to the above letter-headed Pharmacy via fax, E-mail, or personal delivery. I have been told and I agree that should my attorney not wish to cooperate in protecting the Pharmacy's interest, the Pharmacy will not await payment, but will require my account to be paid immediately and in full.

____ PATIENT SIGNATURE DATE

The undersigned, being of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said company above named.

____ ATTORNEY SIGNATURE DATE

Please note that every effort will be made to bill all available medical payment insurance coverage, contingent upon said insurance information being provided by the patient or by his/her attorney to Pharmacy prior to services being provided. By signing this document, I authorize and request my insurance company to pay directly to the Pharmacy the amount due on my claim for services rendered to me or my dependent.

A photocopy of this document shall be considered as valid as the original.