

SPECTRUM REHABILITATION CENTERS, INC.

SPECTRUM REHABILITATION CENTERS, INC. - FAX TRANSMITTAL FORM

TO (receiver's): Haytham Faraj

COMPANY NAME/DEPT. _____

RECEIVER'S FAX #: (202) 318-7652

FROM (sender's name): Bradley G. Sewick, Ph.D.

Sender's Fax #: (248) 350-1216

RE: LIEN ON (CLIENT/PATIENT NAME) Faraj, Sekneh

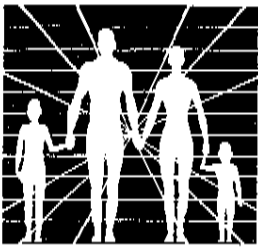
OF PAGES SENT (including this cover sheet): 2

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I certify that on 5/17/10, I faxed the attached lien to Haytham Faraj and that on the same day I personally deposited the lien in the U.S. mail to this individual.

[Signature]
staff signature

5/17/10
date



SPECTRUM REHABILITATION CENTERS, INC.

A. I, Sehneh Farad understand that I am personally responsible for
(print full name)

all charges for services provided to me by Spectrum Rehabilitation Centers, Inc. and Bradley G. Sewick, Ph.D. I instruct my attorney to withhold from any and all judgements or settlements monies owed to Spectrum Rehabilitation Centers, Inc. and Bradley G. Sewick, Ph.D. prior to any distribution of any judgements or settlements to me. I further grant Spectrum Rehabilitation Centers, Inc. and Bradley G. Sewick, Ph. D. A Lien against any judgements or settlements, for any and all services from the first date of service, _____ throughout the pendency of my litigation. I further extend this Lien to any settlements or litigation proceeds, including third party actions for payments of services provided by Spectrum Rehabilitation Centers, Inc., and Dr. Bradley G. Sewick, even if all or part of these services may in theory be covered by a health insurance carrier. It is my understanding, that if at a later time Spectrum Rehabilitation Centers, Inc., receives duplicate payment from a third party for these services, that Spectrum Rehabilitation Centers, Inc. will refund the excess to me.

5/12/10
Date

Sehneh Farad
Patient/Client

Date

Guardian (if applicable),
Relationship to Patient/Client

B. I, _____, Attorney for _____
agree to comply with the above instructions.

Date

Attorney