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

Please Note: This facsimile, including attachments, may include protected health information (PHI), confidential and/or proprietary information, and may be used only by the person or entity to which it is addressed to or the individual designated to view such information per HIPAA regulations. If the reader of this facsimile is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this facsimile is prohibited. If you have received this facsimile in error, please notify the sender by telephone and return the original message to us by mail as soon as possible.

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.

staff signature

5/17/10
date

SPECTRUM
REHABILITATION CENTERS, INC.

A. I, Sekneh Faraj 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

Sekneh Faraj
Patient/Client

_____
Date

_____
Guardian (if applicable),
Relationship to Patient/Client

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

_____
Date

_____
Attorney

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