Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Certified Chiropractic Sports Physician
702.212.3333 • Fax 702.212.3300
8821 W. Sahara Ave. Ste. 120
Las Vegas, NV 89117
www.LasVegasChiro.com
DrKaldy@LasVegasChiro.com

PATIENT FINANCIAL AGREEMENT

The following agreement applies only to the services actually rendered by KEVIN L. KALDY, DC, PC and in no way obligates a patient to continue the course of treatment recommended.

In the event any unpaid balance is placed for collections, with a 3rd party collections agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly by these individuals to collect amounts owed under this agreement such as court cost, sheriff/constable fees, and interest and late fees.

I,_____, understand that I am fully, financially responsible for all services rendered to me KEVIN L. KALDY, DC, PC I elect to use the following payment plan to finance my care and course of treatment at KEVIN L. KALDY, DC, PC

____ CASH – Payment is due at time of service.

____ INSURANCE – **KEVIN L. KALDY, DC, PC**. will, as a courtesy to me, determine benefits available and submit my insurance claim on a case by case basis. However, I understand that I am responsible for my charges incurred and agree to participate in the collection process of my insurance benefit. I also agree to assign benefits to THE CHIROPRACTIC CENTER OF LAS VEGAS, for services rendered to me.

____ PERSONAL INJURY – I will be utilizing my Medical payment portion of my auto insurance or have hired an attorney to assist me in settlement of my case. I agree to provide the necessary documents and information required to **KEVIN L. KALDY, DC, PC**, necessary for the collection of services rendered. I understand that the use of my Medical Payments portion of my auto insurance may not cover the entire bill and I may owe a balance.

____ WORKER'S COMPENSATION – I have been injured while working and have completed the documents necessary to open a worker's compensation claim with my employer. I agree to furnish **KEVIN L. KALDY, DC, PC**, with the information needed to establish the work relatedness of my injury.

Keeping your appointments is very important to the your treatment progress. We hold an appointment time for you each day, therefore, should you find it necessary to reschedule, cancel or are unable to keep a scheduled appointment, please notify our office 24 hours in advance. Failure to do so may result in a $100.00 charge that is NOT covered by your insurance plan.

There are NO refunds for monies collected for services rendered, except if KEVIN L. KALDY, DC, PC errors in the collected amount. Should in the event your account shows a credit, it will be applied to future treatment, services or supplies only.

I understand this financial agreement and agree to comply with its outlined policies.

PATIENT SIGNATURE: _____ **DATE:** _____