Date Faxed: _____

NOTICE OF LIEN

I do hereby authorize **DR. KEVIN L. KALDY of THE CHIROPRACTIC CENTER OF LAS VEGAS,** to furnish you, my attorney/Insurance Carrier, with a full report of the case history, examination, diagnosis, treatment, prognosis of myself in regard to my accident/illness in which I was recently involved.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, **my attorney/insurance carrier, to pay directly** to said doctor such sums for chiropractic and physiotherapeutic services rendered me by reason of this accident/illness from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately. I also, hereby, further give lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic and physiotherapeutic bills submitted by him/her for services rendered me, even in the event I dismiss my attorney or my attorney dismisses me, and I settle directly with the insurance company, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated:_____ Patient Signature:_____

The undersigned, being attorney of record or authorized representative of Insurance Carrier for the above patient, does hereby acknowledge receipt of the above lien, and does agree to honor the agreement to protect adequately said doctor above named to the extent of any settlement, claim, judgment, or verdict. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated_____ Attorney/Authorized Signature: _____

NOTICE: Please date, sign, and return one copy to doctor's office at once by faxing to:

(702) 212-3300

8821 W. Sahara Ave. Ste. 120
Las Vegas, NV 89117
Office: (702) 212-3333 Fax: (702) 212-3300