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When recorded mail to:

Name: _____

Address: _____

_____

City/State/Zip: _____

_____ this area reserved for county recorder

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CAPTION HEADING:

DO NOT REMOVE

This is part of the official document.

The Instrument was Recorded at the Request of:

REED CHIROPRACTIC INC.
250 W. BASELINE ROAD
SUITE 107
TEMPE, AZ 85283

The Record Official is Directed to Return this Instrument or a Copy to the Above Person(s).

NOTICE and CLAIM of MEDICAL CARE LIEN

Effective Date: 11/04/2025	County and State: MARICOPA, AZ
Licensed Health Care Provider (Name, Address, Zip Code) DR. DAVID T. REED 250 W. BASELINE ROAD SUITE 107 TEMPE, AZ 85283	Patient (Name, Address, Zip Code) Rachel Leete 434 E. Balboa Dr. Tempe, AZ 85282
Licensed Health Care Provider, Executive Officer or Agent of Health Care Provider (Name, Address, Zip Code) DR. DAVID T. REED 250 W. BASELINE ROAD SUITE 107 TEMPE, AZ 85283	First Treatment Date: 11/04/2025 Last Treatment Date: TBD Current Balance $926.00 Final Balance: TBD
Amount Due for Patient Care: Current TBD	County in Which Injuries were Sustained: MARICOPA

To the best of Claimant's knowledge, the names and address of all persons, firms or corporations, and the insurance carriers of said persons, firms or corporations claimed by the above-named patient, or by his or her legal representative, to be liable for damages as follows:

1. Rachel Leete,434 E. Balboa Dr., Tempe, AZ 85282
2. USAA PO Box 33490, San Antonio, TX 78265

The above-named Claimant(s), pursuant to the laws of the state of Arizona, do hereby claim a lien upon any and all causes of action, suits to the legal representative of such patient, on an account of injuries giving rise to such causes of action and which necessitated his or her treatment, for the customary charges for health care and treatment of the above-named injured patient in the sum hereinabove claimed to be due. The name and address of the patient as herein before set forth are the same as appear on the records of the Licensed Health Care Provider.

WITNESSETH I am the Licensed Health Care Provider, Executive Officer or Agent of the Health Care Provider named in the forgoing Notice and Claim of Medical Care Lien and that I am authorized to act on behalf of the said Health Care Provider and make this Notice and Claim of Medical Lien for and on behalf of the said Health Care Provider being thereunto duly authorized; that the matters and things contained in the foregoing Notice and Claim of Medical Care Lien are true.

STATE OF ARIZONA
County of Maricopa)
)ss

Licensed Health Care Provider,
Executive Officer or Agent

This instrument was acknowledged before me on this 14 day of November, 2025, by David T. Reed

In witness whereof I herewith set my hand and official seal.

Katharine Marak NOTARY PUBLIC.

03.14.26
Notary Expiration Date

KATHARINE ANN MARAK
Notary Public, State of Arizona
Maricopa County
Commission # 624893
My Commission Expires
March 14, 2026