Apollo Surgery Center

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When recorded mail to:
Apollo Surgery Centers
9458 E Ironwood Square Drive, Suite 101
Scottsdale, AZ 85258

Notice of Claim and Medical Lien

This Notice of claim and Medical Lien is made in accordance with A.R.S. 33-931 and 33-932.
HEALTHCARE PROVIDER: Apollo Surgery Centers
ADDRESS: 9458 E Ironwood Square Drive, Suite 101, Scottsdale, AZ 8528
PATIENT: Leslieann Brescia
ADDRESS: 2611 N Terrace ST , Mesa, AZ 85203
COUNTY OF PROVIDER: Maricopa
DATE(S) OF SERVICE: 11/13/2025
AMOUNT DUE FOR CARE AS OF THIS DATE OF FILING: $ 223,435.30 but not limited to amount listed as ongoing medical care with Arizona Surgical Centers, is to be included with said lien per A.R.S. 33-932. **CALL TO CONFIRM**

TO THE BEST of the healthcare provider's knowledge, the names and address of all persons, films, or corporations claimed by the above named patient, or the patient's legal representative, to be liable for damages are as follows.

Pursuant to the laws of the State of Arizona, specifically, A.R.S. 33-931 and 33-932, et seq., the Healthcare Provider listed above does hereby claim a lien upon any and all cause of action, suits, claims, counter-claims, or demands for damage accruing to the patient named herein, or to the legal representative of such patient, on account of injuries giving rise to such causes of action and which necessitated the patient receiving medical care and treatment for the charges for the medical care and treatment of the above-named injured patient for which party/parties the patient has claimed to be liable and responsible in the sum herein above but also including the amount for ongoing medical treatment claimed to be done. The name and address of the patient as set forth above are the same as the appear on the records of the Healthcare Provider aforementioned.

PAYMENT AND QUESTIONS ARE TO BE MADE TO THE FOLLOWING:
Apollo Surgery Centers
9458 E. Ironwood Square Drive, Suite 101
Scottsdale, AZ 85258
602-603-0400

I, Lizeth Rivas, being sworn upon oath, depose and say: (1) I am the Claimant or the Authorized Agent of Claimant; (2) I have made this Notice and Claim for Healthcare Provider Lien in good faith; (3) The facts herein stated are true and correct to the best of my knowledge.

Claimant or Agent Signature

11/10/25
Date: