

Unofficial Document

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Name: Desert Interventional Spine Consultants

Address: 1410 W Guadalupe Rd Ste 125

City/State/Zip: Gilbert, AZ 85233

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CAPTION HEADING:

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DESERT INTERVENTIONAL SPINE CONSULTANTS

1410 West Guadalupe Road • Building 4 Suite 125 • Gilbert, AZ 85233
Phone (480) 838-1914 Fax (480) 838-9434

PATIENT CONSENT AND DOCTOR'S LIEN

RE: Patient: Reginald Bien Aime
Address: 647 N 110th Pl
Mesa, AZ 85207
Date of Accident/Injury: _____
Date of Service: 10/21/2025 +continuing.
Amount Claimed: _____ +continuing.

Consent and Authorization

The undersigned patient Leopold J. Sica ("Patient") hereby consents to the examination, treatment, procedures and services to be performed by Dr Ajay Yeddu MD ("Provider"), including emergency treatment.

Patient authorizes Provider to release any information needed to process the claims with respect to the examination, treatment, procedures and services rendered by Provider. Patient further directs that a photocopy of this Claim Agreement and Lien be considered as valid as the original.

Patient further authorizes Browne Law Group Unofficial Document
("Attorney") to keep Provider advised of the progress of Patient's court case at reasonable intervals.

The undersigned attorney agrees:

1. To comply with the above "authorization and assignment";
 2. To withhold and pay from the settlement or collection of judgment, the amount of the doctor's charges, after contacting the doctor's office for a current balance;
 3. Advise within ten days of the doctor's requests, the status of the above referenced claim;
 4. To notify the doctor of any changes in the status of the claim which may preclude payment of the doctor's charges.

Date _____ Attorney's Signature _____

Attorney's Printed Name

Irrevocable Lien

Patient hereby authorizes and directs Attorney to pay Provider directly any sums due for medical services rendered to patient. Patient directs Attorney to withhold such funds from any settlement, verdict or judgement that is rendered in the said court case. Patient hereby notifies Attorney that Patient is giving Provider a Lien on these

benefits or settlement proceeds. In consideration for Provider waiting for payment, this Lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient authorized Provider to notify Attorney of this Lien at Provider's discretion and further understands that the Attorney is not required to sign this Lien, but ethically responsible for enforcing it. Patient understands that any settlement verdict or judgement proceeds cannot be distributed to patient without first satisfying this Lien.

Should a dispute arise regarding payment of Provider's charges, Patient authorizes and directs Attorney to hold in escrow all monies sufficient to satisfy this Lien until the dispute can be resolved. Patient acknowledges that it would be a violation of Attorney's ethical duties as to disburse the disputed funds prior to resolution of the Lien dispute.

Patient understands and agrees that even though this Lien has been given, patient remains personally responsible for payment of Provider's fees for all services rendered. Patient is solely responsible to make appropriate arrangements for payment of such fees, including but not limited to Insurance benefits. Patient further understands that such payment is not contingent on any recovery made by Attorney. Patient agrees to waive the defense of Statute of Limitations as it pertains to any claim filed against patient beyond three years (or other statutory) after services were rendered. I agree to promptly notify Dr Ajay Yeddu of any change or addition of attorney(s) in connection with this Lien, and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s). Patient is aware that if their account falls into arrears, the Patient agrees to pay Provider's reasonable costs of collection, including interest, attorney fees, lien fees, court costs and/or third-party collection costs. Patient acknowledges that this obligation to pay Provider's fees is not dependent on the outcome of Patient's court case. Patient further authorizes this document to be filed with the County Registrars office.

11/19/25 Reenawd L. Yeddu SAC 11-19-25
Date Patient's Signature

Ajay Yeddu 11-19-25
Patient's Printed Name

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STATE OF: Arizona) as
COUNTY OF: Maricopa)

I, Ajay Yeddu, M.D., being first duly sworn upon oath, dispose and say:
(1) That I am the person herein named as claimant (or the authorized agent of such claimant), (2) That I have made the Notice and Claim of Medical Lien in good faith; (3) That the facts therein stated are true and correct to the best of my knowledge, information and belief.

Ajay Yeddu
Claimant or Agent

On this 19th day of November, 2025, before me, the undersigned Notary Public, personally appeared,

Ajay Yeddu, to me known to be the individual(s) described in and who executed the foregoing instrument and acknowledged that he (she) (they) executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I here unto set my hand and official seal.

02/01/2029
My Commission Expires

