

NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN

DATE LIEN PREPARED: OCTOBER 24,2025	COUNTY: MARICOPA
CLAIMANT LICENSED HEALTH CARE PROVIDER:	CHRISTIAN HEALTH SERVICES 606 E. BROADWAY RD. MESA AZ. 85204
EXECUTIVE OFFICER OR AGENT OF LICENSED HEALTH CARE PROVIDER: X	
PATIENT INFORMATION: FRANCISCO S. SALVADOR RODRIGUEZ. MARIA ISABEL ROMAN VILLAMONTES, DALEYZA L. ROMAN AND ESTEBAN N. SALADOR 6720 W. CYPRESS ST. PHOENIX AZ. 85035	NAME, ADDRESS AND ZIP AS SAME APPEAR ON THE RECORDS OF CLAIMANT HEALTH CARE PROVIDER:
DATE OF PATIENTS FIRST CARE/TREATMENT DATE OF PATIENT LAST CARE/TREATMENT DATE ON WHICH ON-GOING MEDICAL CARE/TREATMENT WERE PROVIDED (MONTH AND DAY) MARIA ISABEL ROMAN VILLAMONTES. JUN. 03,06,10,12,17,19,24,26.2025 JUL. 03,08,10,15,17,22,24,29,31. 2025 AUG. 05,07,12,14,19,21,26,28. 2025 SEP. 04,09,11,16,18,23.2025 TOTAL: 7,262.00 ESTEBAN N. SALVADOR JUN. 03,06,10,12,17,19,24,26.2025 JUL. 03,08,10,15.2025 TOTAL: 1,208.00	06/03/2025 09/23/2025 FRANCISCO S. SALVADOR RODRIGUEZ JUN. 03,06,10,12,17,19,24,26.2025 JUL. 03,08,10,15,17,22,24,29,31. 2025 AUG. 05,07,12,14,19,21,26,28. 2025 SEP. 04,09,11,16,18,23.2025 TOTAL: 7,712.00 DALEYZA ROMAN L. JUN. 03,06,10,12,17,19,24,26.2025 JUL. 03,08,10,15,17,22..2025 TOTAL: 1,382.00
AMOUNT CLAIMED DUE FOR CARE/TREATMENT: OF PATIENTS \$ 17,564	COUNTY IN WHICH INJURIES WERE SUSTAINED: <u>MARICOPA</u>

TO THE BEST OF CLAIMANT'S KNOWLEDGE, THE NAMES AND ADDRESSES OF ALL PERSONS, FIRMS OR CORPORATIONS AND THE INSURANCE CARRIERS FOR SUCH PERSONS, FIRMS OF CORPORATIONS CLAIMED BY THE ABOVE NAMED PATIENT, OR HIS/HER LEGAL REPRESENTATIVE TO BE LIABLE FOR DAMAGES ARE:

NAME: STATE FARM CLAIMS.

ADDRESS: P.O. BOX 106170, ATLANTA. GA 30348-6170

CLAIM NUMBER.. 03-85T8-57B

CHRISTIAN HEALTH SERVICES 606 E. BROADWAY RD MESA AZ. 85204 TELEPHONE (602) 279- 5288



LUCAS A. RUIZ D.C. / CHIROPRACTIC PHYSICIAN

NATURAL HEALTH CARE: ACUPUNCTURE, X-RAYS, PHYSICAL THERAPY, NUTRITION

DOCTOR'S LIEN

THE ABOVE NAMED CLAIMANTS, IN ACCORDANCE WITH ARIZONA REVISED STATUTES DO HEREBY CLAIM A LIEN UPON ANY AND ALL CAUSES OF ACTION, SUITS, CLAIMS, COUNTERCLAIMS, OR DEMANDS ACCRUING TO THE ABOVE NAMED PATIENT OR LEGAL REPRESENTATIVE OF SUCH PATIENT, AS A RESULT OF INJURIES GIVIN RISE TO SUCH CAUSES OF ACTION AND WHICH MADE NECESSARY HIS/HER TREATMENT, FOR THE CUSTOMARY CHARGES FOR HEALTH CARE TREATMENTS OF THE ABOVE NAMED PATIENT IN THE SUM HERE IN ABOVE CLAIMED TO BE DUE.

STATE OF ARIZONA)

) SS VERIFICATION OF AUTHORIZED AGENT

COUNTY OF MARICOPA)

Lucas A Ruiz BELONG FIRST DULY SWORN, UPON OATH DEPOSES AND SAYS THAT HE/SHE IS THE LICENSED HEALTH CARE PROVIDER, EXECUTIVE OFFICER, OR AGENT OF THE HEALTHCARE PROVIDER ABOVE SUBSCRIBED AND THAT HE/SHE IS AUTHORIZED TO ACT ON BEHALF OF SAID HEALTH CARE PROVIDER.

Lucas A Ruiz ^{Unofficial Document} BEING DULY SWORN, UPON OATH DEPOSES AND SAYS THAT HE/SHE IS THE LICENSED HEALTH CARE PROVIDER, EXECUTIVE OFFICE, OR AGENT OF THE HEALTH CARE PROVIDER NAMED IN THE PRECEDING NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN, THAT HE IS AUTHORIZED TO ACT ON BEHAVE OF SAID HEALTH CARE PROVIDER, THAT HE/SHE DID WITHIN FIVE (5) DAYS AFTER THE RECORDING OF SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN AND ON THE **24 DAYS OF OCTOBER, 2025** DID SEND BY CERTIFIED MAIL, POSTAGE PREPAID, COPIES THEREOF TO EACH PERSON, FIRM, OR CORPORATION, AND THE INSURANCE CARRIER OF SUCH PERSONS, FIRM OR CORPORATION CLAIMED IN THE SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN TO BE LIABLE FOR DAMAGES AT THE ADDRESSES GIVEN IN THE PRECEDING STATEMENT.

LICENSED HEALTH CARE PROVIDER,

EXECUTIVE OFFICER OR AGENT THEREOF.

SUBSCRIBED AND SWORN TO ME.

A NOTARY PUBLIC ON THE

24 DAY OF October, 2025.

NOTARY PUBLIC

