When recorded mail to:

ML
Yo

ARIZONA CHIROPRACTIC GROUP
PREVENTION, WELLNESS, AND INJURY CARE
Dr. Alejandro A. Mioni D.C.
Dr. Samantha Befidi D.C.
422 E. Southern Ave,
Tempe, AZ 85282
Phone: 480-497-9399
Fax: 480-497-9229

Medical Lien

Patients Name: Trinity Ha DATE OF BIRTH 07/30/06

HOME ADDRESS: 2340 E University Dr lot 190 CITY Tempe

STATE: AZ ZIP 85281 DATE OF ACCIDENT: 10/14/25

FIRST D.O.S/AMOUNT 10/24/2025/ $715.00 TREATING BEYOND 30 DAYS: Y/(N)

I hereby acknowledge that I am receiving or are about to receive health care at Arizona Chiropractic Group. I understand that payment is expected upon rendering of service. However, since I have third party insurance and/or first party insurance (uninsured motorist coverage, non-insured motorist coverage, or medical payments coverage), and/or general liability insurance, I agree to assign the benefits payable for my medical bills to Arizona Chiropractic Group.

In turn, Arizona Chiropractic Group agrees to extend credit to me and wait for its payment until proceeds are mailed upon settlement. If benefits are not assignable, I agree to pay for these services in full within ten days of receipt of the settlement proceeds of the claim. I further understand that each day after the tenth day Arizona Chiropractic Group does not receive its balance in full, an interest of 1.8% compounded monthly interest will be assessed to my balance.

Furthermore, if Arizona Chiropractic Group should have to retain an attorney to collect said sums, I understand that I am going to be held responsible for any and all of the attorney fees incurred in the collection of this account.

SIGNED AND DATED THIS MONTH 10 DAY OF 24 20 25, AT TEMPE, ARIZONA

Patient's Signature

Witness Signature

Med-pay Insurance Company: _____ Claim#: _____

Address: _____ City: _____ State: _____ Zip: _____

Third Party Insurance Company: _____ Claim#: _____

Address: _____ City: _____ State: _____ Zip: _____

Attorney Name: _____ Firm Name: _____

Phone: _____ City: _____ State: _____ Zip: _____