

# Unofficial Document

Service dates: 10/15/2025 Plus  
and still treating  
Account balance \$650 plus  
cost of additional treatments

11  
Yo

## LIEN - MEDICAL

### AGREEMENT BY PATIENT GRANTING PHYSICIAN A LIEN AND PROMISING TO PAY PHYSICIAN FOR MEDICAL SERVICES

Patient Name: **Drake Brian Muckridge**

DOB: **02/16/1996**

Address: **13601 S 44th St Apt 3123**

City: **Phoenix**

State: **AZ** Zip: **85044**

Date of Accident: 09/04/2025

**THIS IS A LEGAL DOCUMENT READ THE FOLLOWING CAREFULLY**

**Drake Brian Muckridge**

I, **Drake Brian Muckridge**, do hereby acknowledge and grant to my physician at, **James KellerShabrokh, D.O.,P.C., dba Comprehensive Pain Management (CPM)** a LIEN as surely for payment for any and all medical services already rendered to me or to be rendered on my behalf, the AMOUNT of any said LIEN to be equal to the total dollar amount already billed or to be billed by said physician for ANY and ALL medical services incurred and provided to me as a result of the accident, injury, or illness relating to the above. I authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for the service rendered to me. This LIEN shall be effective against ANY and ALL payment(s), settlement(s), judgment(s), award(s), claim(s) or verdict(s) made by me or to me, entered on my behalf, or agreed to by my legal representative, which relate(s) to the above-numbered claim(s), accident, injury, or illness, whether or not said payments are made by 3<sup>rd</sup> party payers and/or 1<sup>st</sup> party payers under the provisions of any first party agreements which inures to my benefit, including liability, medical payment, health insurance, uninsured and under insurance benefits. I UNDERSTAND that I am, and continue to be, PERSONALLY RESPONSIBLE for ANY and ALL MEDICAL BILLS presented to me by my physician, and that this agreement granting my physician a LIEN is made for valuable consideration received by me from my physician, i.e. his agreement to await payment for said medical services until said payment(s), settlement(s), judgment(s), award(s), claim(s) or verdict(s) is/are received or entered, OR until a REASONABLE TIME has passed since said medical service(s), whichever occurs FIRST. I FURTHER ACKNOWLEDGE that even if I do not receive any monies or payments as a result of my accident or illness claim(s), I HEREBY AGREE that I still owe my physician, and hereby PROMISE TO PAY my physician in a timely manner, for all medical services rendered by him to me. This PROMISE TO PAY for medical services is NOT contingent upon any payment(s), settlement(s), judgment(s), award(s), claim(s) or verdict(s) which I may receive. I authorize CPM, to sign my name to any check written in both our names where such checks are in payment for its services regarding my injury. I hereby agree that I shall not submit any of the medical bills arising out of this lien for payment to any government sponsored health plan including, but not limited to, Medicare and AHCCCS unless it is agreed by you, my said provider/doctor, to do so. Finally, this confirms that as a special consideration to you, my physician/provider, I agree that I will not seek to have you pay or share in (or be required to pay any proportional share of) any of the collection costs, including attorney fee and costs incurred by me in obtaining the common fund recovery (the settlement, judgment, or award as to my third party claim for my accident injuries) from which you are likely to be paid as authorized pursuant to LaBombard v. Samaritan Health Systems, 195 Ariz 543, 991 P.2d 446 (App. 1998). Instead, I agree to pay the full amount of the reasonable treatment billings of you, my said physician/provider, for treatment of my accident-related injuries, without any reduction for any proportional share of my legal fees and costs in obtaining the common fund recovery, and without reduction of your reasonable charges for any other reason [to the full extent my recovery allows]. Also, this lien is enforceable under AZ law pursuant to ARS §33-931 et. al. It is also enforceable by creating a personal contract between CPM and you and your lawyer and provides guarantees and security for payment CPM's bill for services by you and your attorney. I authorize CPM to sign my name to any check written in both our names where such checks are in payment for its services regarding my injury. This consensual lien and assignment is to continue, enforce, and be binding if I should decide to change physicians and/or attorneys in the future. I have read, fully understand, and hereby agree to this document, and hereby sign with the full intent that I be legally bound to the terms promises and conditions contained therein.

James KellerShabrokh, D.O.,P.C.,dba  
**COMPREHENSIVE PAIN MANAGEMENT**  
8841 E. Bell Road, #101  
Scottsdale, AZ 85260  
(602) 971-8200 (O) (602) 971-8201 (F)

(Signed) 

Date: 10/15/25

Name of at fault driver, insurance co, location of accident:

I declare under penalty of perjury that the foregoing is true and correct.

*Jocelyn Chavez*

11/06/2025

Date

Employee Name

I understand, being attorney of record for the above named patient/client, that the above is a valid lien, I hereby acknowledge receipt of same, and I agree to honor same.

Name \_\_\_\_\_ Attorney Signature \_\_\_\_\_ Date \_\_\_\_\_